



STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: August 21, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016866

[REDACTED]

Dear [REDACTED],

On June 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 4, 2017 eligibility determination notice and the failure of NYSOH to issue a timely determination of your eligibility for retroactive coverage for January 2017.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY - Spanish: 1-877-662-4886).

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Decision

Decision Date: August 21, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016866



Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Is your appeal of the January 4, 2017 eligibility determination notice timely?

Did NY State of Health (NYSOH) provide you with a timely determination of your eligibility for retroactive coverage for the month of January 2017?

Procedural History

NYSOH issued a notice dated January 4, 2017 stating that you remained conditionally eligible for Medicaid, effective January 1, 2017. The notice stated that you had to provide proof of your income by January 7, 2017 to confirm your eligibility. The notice contained a "Document List" indicating acceptable documents of various types of income. The list indicated that to prove self-employment income an applicant must submit records of detailed earnings and expenses for the last three months, business payroll and records for the last three months, or a copy of a signed and dated tax return for the previous year if representative of attested income for the current year.

On February 10 2017, NYSOH received an updated application submitted on behalf of you and your family.

On February 11, 2017, NYSOH issued a notice stating the income information listed in the application did not match information received from state and federal data sources. The notice directed you to submit proof of your income by March 4, 2017 or NYSOH would not be able to determine your eligibility for health insurance.

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On February 21, 2017, NYSOH received several updated applications submitted on behalf of you and your family.

On February 22, 2017, NYSOH issued a notice stating the income information listed in the application did not match information received from state and federal data sources. The notice directed you to submit proof of your income by March 4, 2017 or NYSOH would not be able to determine your eligibility for health insurance.

On March 7, 2017, NYSOH issued an eligibility determination notice, based on a March 6, 2017 systematic eligibility redetermination, stating you were eligible for Medicaid, effective February 1, 2017.

Also on March 7, 2017, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective April 1, 2017.

Additionally, on March 7, 2017, NYSOH issued a notice indicating your newborn was eligible for retroactive Medicaid coverage for the month of January 2017. The notice made no mention of your eligibility for coverage.

On March 15, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not eligible for full Medicaid coverage for the month of January 2017.

On June 22, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documents.

On June 27, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1. The record closed thereafter.

Findings of Fact

A review of the record support the following findings of fact:

- 1) According to your account, you were enrolled in a Medicaid Managed Care plan through December 31, 2017.
- 2) Your application was updated on September 12, 2016 to report your pregnancy for the first time and updated several times thereafter with different income information, including attested self-employment income for you.

- 3) According to your account, NYSOH was unable to verify the income information listed in the applications and you were determined conditionally eligible for Medicaid with proof of income requested to confirm your eligibility.
- 4) The November 24, 2016 notice requesting additional documentation included a "Document List" indicating acceptable documents of various types of income. The list indicated that to prove self-employment income an applicant must submit records of detailed earnings and expenses for the last three months, business payroll and records for the last three months, or a copy of a signed and dated tax return for the previous year if representative of attested income for the current year.
- 5) You submitted income documentation in December 2016 that was invalidated by NYSOH as insufficient proof of your self-employment income and additional documentation was requested.
- 6) NYSOH redetermined your eligibility several times in December 2016 finding you continued to be conditionally eligible for Medicaid, effective January 1, 2017, and requested additional income documentation by January 7, 2017 to confirm your eligibility.
- 7) The last notice confirming your conditional Medicaid eligibility, as of January 1, 2017, was issued by NYSOH on January 4, 2017 and, again, requested additional income documentation to confirm your eligibility by January 7, 2017.
- 8) There is no record of NYSOH receiving further documentation of your income by January 7, 2017.
- 9) Your account confirms you had presumptive Medicaid coverage only in the month of January 2017.
- 10) You testified your youngest child was born in [REDACTED] 2017 and you have outstanding medical bills from the hospital relating to the birth of your child that Medicaid is not covering.
- 11) On February 10, 2017, NYSOH received an updated application submitted on behalf of you and your family. That application indicated that only your newborn was requesting "help paying for medical bills from the last 3 months."
- 12) Also on February 10, 2017, NYSOH received a copy of an employment letter for your spouse indicating he earns a gross monthly salary of \$3,250.00. NYSOH verified this document on March 5, 2017.

- 13) On February 22, 2017, NYSOH received several updated applications submitted on behalf of you and your family. All applications indicated that only your newborn was requesting “help paying for medical bills from the last 3 months.”
- 14) You testified that you were working with a Navigator in February 2017 to request retroactive coverage for you and your newborn for the month of January 2017. You testified you were on the phone with the Navigator and she asked if you needed help paying for medical bills from prior months. You testified you told her that you needed help with bills from January 2017. You testified the Navigator informed you that she was unable to click yes on the application. You testified the Navigator told you that it was likely due to your pending eligibility status at the time.
- 15) According to your account, NYSOH did not receive any additional documentation of your income until February 23, 2017, when a copy of a spreadsheet providing your attested income for the months of October, November, and December 2016 was uploaded. The spreadsheet also indicated that your income for the month of January 2017 was \$0.00. This documentation was verified by NYSOH on March 6, 2017.
- 16) Your eligibility was systematically redetermined on March 6, 2017, following verification of your income documents, and you were determined fully eligible for Medicaid, effective March 1, 2017.
- 17) Your account confirms that your newborn was found eligible for retroactive Medicaid for the month of January 2017, but you never received a determination regarding your eligibility for retroactive Medicaid for the month of January 2017.
- 18) You testified the only household income for the month of January 2017 was your spouse’s income of \$3,250.00. You testified that you did not work in January 2017, but you would check your records to determine whether you received any outstanding payments for work done in previous months.
- 19) On June 27, 2017, NYSOH Appeals Unit received a letter from you indicating that you confirmed you did not receive any paycheck or compensation in the month of January 2017.
- 20) A formal appeal regarding your eligibility for full Medicaid coverage for the month of January 2017 was filed on your behalf on March 15, 2017.
- 21) You testified, and your applications indicate, you will file your 2017 tax return with a tax filing status of married filing jointly and you will claim 11 dependents on that tax return.

22) Your applications indicate you reside in Kings County.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by NYSOH to provide timely notice of an eligibility determination; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time-period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the

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inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f)).

Legal Analysis

The first issue under review is whether your appeal of the January 4, 2017 eligibility determination notice was timely.

According to your account, you updated your application on September 12, 2016 to report your pregnancy for the first time. Due to your pregnancy and NYSOH being unable to verify the income information in your subsequent updated applications, you were determined presumptively eligible for Medicaid, effective January 1, 2017, and you were directed to submit proof of your income. Your account confirms that NYSOH invalidated income information you submitted in December 2016 and redetermined your eligibility several times in that month finding you conditionally eligible for Medicaid, effective January 1, 2017, each time. Additional income documentation was requested by January 7, 2017 to confirm your eligibility.

Due to the outstanding income document request and NYSOH's inability to verify your household income, your account confirms that you had presumptive Medicaid coverage only in the month of January 2017. You are appealing your eligibility for coverage for the month of January 2017 insofar as you were not eligible for full Medicaid coverage for that month. The last notice confirming your presumptive Medicaid eligibility, as of January 1, 2017, was issued by NYSOH on January 4, 2017.

Pursuant to the above cited regulations, individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your presumptive Medicaid eligibility for the month of January 2017, as confirmed in the January 4, 2017 eligibility determination notice, an appeal should have been filed by March 5, 2017. According to your account, a formal appeal was not filed in this matter until March 15, 2017, after the 60-day period in which to appeal had passed. Additionally, there is no evidence of any attempt to appeal this notice which would justify tolling the statutory time-period.

Therefore, given the facts of the case, there has been no timely appeal of the January 4, 2017 eligibility determination notice, and your appeal on the issue of your presumptive Medicaid eligibility for the month of January 2017 is **DISMISSED**.

It is noted, however, that the record establishes that you did not submit sufficient evidence of your self-employment income until you uploaded the spreadsheet of your monthly income on February 23, 2017. Accordingly, you would not have been eligible for full Medicaid coverage in the month of January 2017 even if the Appeals Unit had jurisdiction to address the merits of your appeal on this point.

The second issue under review is whether NYSOH provided you with a timely determination of your eligibility for retroactive coverage for the month of January 2017.

According to your account, updated applications were filed on behalf of you and your family on February 10, 2017 and on February 22, 2017. Each application indicated *your newborn* was requesting “help paying for medical bills from the last 3 months.” However, each application stated that you personally were not requesting retroactive coverage.

You testified that you were working with a Navigator in February 2017 to request retroactive coverage for you and your newborn for the month of January 2017. You testified you were on the phone with the Navigator and she asked if you needed help paying for medical bills from prior months. You testified you told her that you needed help with bills from January 2017. You testified the Navigator informed you that she was unable to click yes on the application. You testified the Navigator told you that it was likely due to your pending eligibility status at the time.

Given the numerous application submitted in February 2017 requesting retroactive Medicaid coverage for your newborn and your account confirming your pending Medicaid status at the time of the applications, your testimony regarding your inability to submit a request for retroactive Medicaid coverage for the month of January 2017 on the February 2017 applications due to your pending status is deemed credible.

Pursuant to the regulations, NYSOH must provide Medicaid applicants with notice of their eligibility determination within 45 days from the date of the application.

According to the evidence you attempted to apply for retroactive Medicaid coverage for the months of January 2017 several times in February 2017. Although NYSOH issued a notice on March 6, 2017, stating your newborn child was eligible for retroactive Medicaid coverage for the month of January 2016, that notice made no mention of your eligibility for coverage. Your account confirms that, to date, no such eligibility determination has been issued.

Your account confirms that NYSOH validated your spouse’s February 10, 2017, employment letter indicating his gross monthly salary is \$3,250.00 and the spreadsheet you uploaded on February 23, 2017 indicating your monthly self-

employment income for the month of January 2017 was \$0.00. Accordingly, there is sufficient evidence in the record to establish that your monthly household income for the month of January 2017 was \$3,250.00.

Accordingly, your case is RETURNED to NYSOH to determine your eligibility for retroactive Medicaid coverage for the month of January 2017 using a gross monthly household income of \$3,250.00 and a household size of 13. NYSOH is directed to provide you with a timely notice of your eligibility.

Decision

Your appeal of the January 4, 2017 eligibility determination notice is untimely and is DISMISSED.

Your case is RETURNED to NYSOH to determine your eligibility for retroactive Medicaid coverage for the month of January 2017 using a gross monthly household income of \$3,250.00 and a household size of 13. NYSOH is directed to provide you with a timely notice of your eligibility.

Effective Date of this Decision: August 21, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to determine your eligibility for retroactive Medicaid coverage for the month of January 2017. You will receive an updated eligibility determination notice from NYSOH.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:
Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061
- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

Your appeal of the January 4, 2017 eligibility determination notice is untimely and is **DISMISSED**.

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Your case is RETURNED to NYSOH to determine your eligibility for retroactive Medicaid coverage for the month of January 2017 using a gross monthly household income of \$3,250.00 and a household size of 13. NYSOH is directed to provide you with a timely notice of your eligibility.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to determine your eligibility for retroactive Medicaid coverage for the month of January 2017. You will receive an updated eligibility determination notice from NYSOH.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:



Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

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এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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