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

# Notice of Decision

Decision Date: February 05, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020410

[redacted]

[redacted]

On December 14, 2017, your attorney appeared by telephone on your behalf at a hearing on your appeal of NY State of Health's alleged failure to issue an eligibility determination of your request for retroactive Medicaid assistance for September 2015.

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

# Decision

Decision Date: February 05, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000020410

[redacted]

## Issue

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

> Did NY State of Health (NYSOH) improperly fail to provide you with a timely determination of your eligibility for retroactive Medicaid assistance for September 2015?

## Procedural History

On September 25, 2015, an application for financial assistance was submitted on your behalf stating, in part, that you had annual household income of $18,200.00.

Also on September 25, 2015, you uploaded documentation regarding your income, in which you claimed you earned $350.00 per week.

On September 26, 2015, NYSOH issued a notice stating that the income information you provided did not match information NYSOH obtained from state and federal sources. You were directed to provide proof of income by October 11, 2015 or NYSOH would not be able to determine your eligibility for health care. The notice included a "Documentation List" that provided various forms of acceptable documents to prove specific types of income. The list indicated that to prove wages, an applicant must submit the last four weeks of pay stubs or a signed and dated letter from the employer or company letterhead.

On September 30, 2015, the income documentation you submitted on September 25, 2015 was invalidated.

On December 23, 2015, an updated application for financial assistance with health insurance was submitted on your behalf requesting help paying for medical bills for the previous three months.

On December 24, 2015, January 13, 2016, and January 23, 2016, NYSOH issued notices stating that the income information you provided was not confirmed by information NYSOH obtained from state and federal sources. You were directed to provide proof of income or NYSOH would not be able to make an eligibility determination.

No further documentation regarding your household income from September 2015 was submitted to NYSOH.

In May 2016, you submitted a self-declaration of income, purportedly signed on May 28, 2016, stating that you earned $300.00 per week, you were paid in cash, and your employer refused to provide a letter regarding your income.

On July 8, 2017, your certified application counselor spoke to NYSOH's Account Review Unit and appealed insofar as you were denied retroactive Medicaid coverage for September 2015. Your authorized representative also uploaded a written appeal of a May 5, 2017 denial of your request for retroactive Medicaid assistance.

On December 14, 2017, your Authorized Representative represented you at a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until December 21, 2017 to allow your Authorized Representative to submit supporting documents.

On December 21, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1, the record was closed that day.

## Findings of Fact

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

1) You submitted a written authorization that authorized [redacted] of [redacted] to appear on your behalf. [redacted] clarified that she was appearing on your behalf as your legal counsel.

2) Your July 8, 2017 appeal request states that you are appealing a "Notice of Denial dated May 5, 2017."

3) At the hearing, [redacted] stated that this statement was incorrect insofar as there was no "Notice of Denial dated May 5, 2017" and that

the appeal request was referring to a May 10, 2017 email from the Department of Health which denied your retroactive Medicaid for the month of September 2015.

4) At the hearing, [redacted] stated that you were appealing NYSOH's failure to make a determination regarding your request for retroactive Medicaid for the month of September 2015.

5) You applied for financial assistance with health insurance on September 25, 2015.

6) Your application submitted on September 25, 2015 stated you were in a three-person household.

7) Also on September 25, 2015, you uploaded a Declaration of Income dated September 17, 2015 stating that you are paid in cash, and that you cannot obtain a letter from your employer because you work [redacted] including [redacted] The Declaration of Income states that for the month of September 2015 that you were paid $350.00 per week, without specifying how many times you were paid in September. The Declaration of Income was signed by a certified application counselor.

8) NYSOH records reflect that on September 30, 2015, NYSOH determined your proof of income dated September 17, 2015 was invalid. NYSOH records state "Invalid Proof of Income. [redacted] submitted a DOH-5018 for self-employment which is not valid. Please submit 3 months-worth of detailed business earnings and expenses or 2014 1040 tax forms, signed and dated. Notice sent."

9) [redacted] stated that the Declaration of Income dated September 17, 2015 is the only proof of income you could provide for September 2015. She stated that you were unable to obtain income documentation from your employers, without further explanation.

10) You applied for financial assistance on December 23, 2015 and requested help in paying for medical bills for the previous three months. [redacted] clarified that you are only seeking retroactive Medicaid for the month of September 2015.

11) Your account confirms that NYSOH has not issued a determination of your eligibility for the month of September 2015.

12) [redacted] stated that you have medical bills which were incurred in September 2015.

13) Your application indicates that you live in Nassau County.

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

## Applicable Law and Regulations

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

Medicaid for Adults between the Ages of 19 and 65

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR

§ 435.4). On the date of your application, that was the 2015 FPL, which is $20,090.00 for a three-person household (81 Federal Register 4036).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

## Legal Analysis

The issue under review is whether NYSOH failed to provide you with a timely determination of your eligibility for retroactive Medicaid coverage for the month of September 2015.

You applied for financial assistance with your health insurance on September 25, 2015.

On September 25, 2015, you uploaded a Declaration of Income dated September 17, 2015 stating that you are paid in cash, and that you cannot obtain a letter from your employer because you work [redacted] including [redacted]. The Declaration of Income states that for the month of September 2015 that you were paid $350.00 per week. The Declaration of Income was signed by a certified application counselor.

On September 26, 2015, NYSOH issued a notice stating that the income information you provided was not confirmed by any information NYSOH obtained from state and federal sources. You were directed to provide proof of income by October 11, 2015 or NYSOH would not be able to determine your eligibility for health care. The notice included a “Documentation List” which provided various forms of acceptable documents to prove specific types of income. The list indicated that to prove wages an applicant must submit the last four weeks of pay stubs or a signed and dated letter from the employer or company letterhead.

NYSOH records reflect that on September 30, 2015, NYSOH determined your proof of income dated September 17, 2015 was invalid. NYSOH records state “Invalid Proof of Income. [redacted] submitted a DOH-5018 for self-employment which is not valid. Please submit 3 months-worth of detailed business earnings and expenses or 2014 1040 tax forms, signed and dated. Notice sent.”

You updated your application for financial assistance on December 23, 2015 and requested help in paying for medical bills for the prior three months. [redacted] stated that you are seeking retroactive Medicaid only for September 2015. That application indicated that you earn $350.00 weekly and listed your monthly income as $1,516.67 in each of those months. According to your account, NYSOH was unable to verify the income listed in your application through any state or federal sources.

Although in September 2015 NYSOH received a Declaration of Income from you dated September 17, 2015, stating that during September 2015 you earned $350.00 per week, this document was invalidated by NYSOH because it did not comply with the document request. In the Declaration of Income, you state that you were unable to obtain letters from your employers because you work [redacted]. There is no explanation why you were unable to obtain letters from your employers regarding your September 2015 income.

Your attorney [redacted] stated at the hearing that the Declaration of Income dated September 17, 2015 is the only proof of income which you were able to provide for September 2015. She stated that you were unable to obtain income documentation from your employers. There has been no evidence presented regarding any efforts to contact your former employers or the reasons why they would not cooperate with a request for proof of income for September 2015.

It is concluded that the Declaration of Income submitted in September 2015 was insufficient proof of your income in September 2015 because it failed to advise why you were unable to provide letters from your employers for the month of September 2015 to verify your gross income. As the Declaration of Income, you provided does not provide proof of your gross income nor does it provide an explanation of why you could not obtain proof of income from your employers for the month of September 2015, the document is not reliable evidence of your income.

With regard to your appeal on the issue of NYSOH's failure to issue a timely determination of your eligibility for retroactive Medicaid coverage for the month of September 2015, as discussed above, it is concluded that you have failed to submit sufficient documentation of your income for that month, and therefore have not submitted a complete application. NYSOH has therefore not failed to issue a timely determination of your eligibility of retroactive Medicaid coverage for the month of September 2015.

## Decision

NYSOH has not failed to issue a timely determination of your eligibility of retroactive Medicaid coverage for the month of September 2015, and there is no NYSOH decision for the Appeals Unit to review.

**Effective Date of this Decision:** February 05, 2018

## How this Decision Affects Your Eligibility

There is insufficient evidence in the record to determine your eligibility for retroactive Medicaid coverage for the month of September 2015.

## If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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.

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

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).

- 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

NYSOH has not failed to issue a timely determination of your eligibility of retroactive Medicaid coverage for the month of September 2015.

There is insufficient evidence in the record to determine your eligibility for retroactive Medicaid coverage for the month of September 2015.

## Legal Authority

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

## A Copy of this Decision Has Been Provided To:

[redacted]

[redacted]

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).

## 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)**

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।

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).

**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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई नि:शुल्क 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 yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

**اردو (Urdu)**

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 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 דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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