



STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: December 18, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000022460

[REDACTED]

Dear [REDACTED]

On November 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's alleged failure to issue a timely Medicaid eligibility determination from your January 14, 2017 application.

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
PO 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(b).

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: December 18, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000022460



Issue

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

Did NY State of Health (NYSOH) fail to issue a timely Medicaid eligibility determination for your household from your January 14, 2017 application?

Procedural History

On January 14, 2017, NYSOH received an application for financial assistance with health insurance.

On January 15, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal data sources. You were requested to provide proof of income for your household by January 29, 2017 so that an appropriate determination could be issued.

Also on January 15, 2017, NYSOH issued a disenrollment notice stating that the Medicaid coverage for you, your spouse, and your son would end effective January 31, 2017.

On February 12, 2017, NYSOH received a spreadsheet reflecting expenses incurred by you and your spouse during 2016 and self-employment income for you and your spouse between November 18, 2015 and November 16, 2016.

On February 23, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the information contained in your application. You

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were requested to provide additional income documentation by March 15, 2017 to confirm your household's eligibility.

On March 14, 2017, NYSOH received (1) several spreadsheets reflecting you and your spouse's joint expenses and income during 2016 and (2) several spreadsheets reflecting you and your spouse's joint expenses and income during 2017, between January 5, 2017 and March 8, 2017 specifically.

On March 24, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the information contained in your application. You were requested to provide additional income documentation by April 14, 2017 to confirm your household's eligibility.

On April 13, 2017, NYSOH received a signed and dated spreadsheet reflecting you and your spouse's three-month income and expense budget sheet for months of January, February, and March 2017.

On April 19, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the information contained in your application. You were requested to provide additional income documentation by May 14, 2017 to confirm your household's eligibility.

On April 24, 2017, NYSOH received (1) a signed and dated spreadsheet reflecting your three-month income and expense budget sheet for months of January, February and March 2017, and (2) a signed and dated spreadsheet reflecting your spouse's three-month income and expense budget sheet for months of January, February, and March 2017.

On April 26, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the information contained in your application. You were requested to provide additional income documentation by May 14, 2017 to confirm your household's eligibility.

On May 10, 2017, NYSOH received (1) a signed worksheet reflecting your gross earnings and expenses during the months October, November and December 2016, and (2) a signed worksheet reflecting your spouse's gross earnings and expenses during the months October, November, and December 2016.

Also on May 10, 2017, NYSOH redetermined your household's eligibility for financial assistance with health insurance.

On May 11, 2017, NYSOH issued an eligibility determination notice stating that you, your spouse, and your younger child were eligible for Medicaid, effective May 1, 2017.

On May 12, 2017, NYSOH issued an enrollment notice confirming your selection of a Medicaid Managed Care (MMC) plan for your family's enrollment as of May 11, 2017, with such coverage to begin effective June 1, 2017.

On September 15, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as NYSOH failed to issue a timely Medicaid eligibility determination for you, your spouse, and your youngest child, and requested a Medicaid start date no later than February 1, 2017.

On November 13, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: reasonably acceptable documentation reflecting the earnings and expenses of you and your spouse during the month of April 2017. The record was to be closed on November 20, 2017, or upon the receipt of the above referenced documents, whichever occurred earlier.

On November 19, 2017, NYSOH Appeals Unit received through your NYSOH account (1) a worksheet reflecting your earnings and expenses during the month of April 2017, and (2) a worksheet reflecting your spouse's earnings and expenses during the month of April 2017.

The record was closed on November 19, 2017.

Findings of Fact

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

- 1) You testified that you are appealing for yourself, your spouse, and your youngest child to be found eligible for Medicaid as of February 1, 2017.
- 2) According to your NYSOH account, NYSOH received your updated application for financial assistance on January 14, 2017. A determination as to your eligibility could not be made on that day because the income information in your application did not match the information from state and federal data sources.
- 3) You testified that after learning that additional documentation was required, you immediately provided NYSOH with records of you and your spouse's self-employment earnings that were available to you at that time.
- 4) On February 12, 2017, you provided to NYSOH a spreadsheet reflecting you and your spouse's self-employment income and expenses for the period between November 18, 2015 and November 16, 2016. This document reflected a combined gross income of \$19,495.03 and combined expenses of \$7,152.74.

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- 5) You testified that you provided a spreadsheet containing your 2016 earnings and expenses at the request of a NYSOH representative.
- 6) On March 14, 2017, you provided to NYSOH a spreadsheet reflecting the combined gross income and expenses for you and your spouse for the period between January 5, 2017 and March 8, 2017. This set of documents reflected a total gross income of \$1,136.45 and combined expenses of \$1,616.72. You also provided an updated version of your household's combined business income and expenses for 2016.
- 7) On April 13, 2017, you provided to NYSOH a three-month income and expense spreadsheet reflecting your combined income and expenses for the months of January, February and March 2017. This document reflected that you incurred a monthly net loss of \$230.00 during that time.
- 8) On April 24, 2017, you provided to NYSOH (1) a signed and dated spreadsheet reflecting your three-month income and expense budget sheet for months of January, February and March 2017, which indicated a monthly net loss of \$285.00, and (2) a signed and dated spreadsheet reflecting your spouse's three-month income and expense budget sheet for months of January, February, and March 2017, which reflected a monthly net profit of \$55.00.
- 9) On May 10, 2017, you provided to (1) a signed and dated spreadsheet reflecting your three-month income and expense budget sheet for months of October, November and December 2016, which indicated a monthly net profit of \$1,159.85, and (2) a signed and dated spreadsheet reflecting your spouse's three-month income and expense budget sheet for months of October, November, and December 2016, which reflected a monthly net profit of \$1,756.62.
- 10) Based on the documentation you provided to May 10, 2017, you, your spouse, and your younger child were found eligible for Medicaid, effective May 1, 2017.
- 11) You testified that you found the process of providing documentation to NYSOH problematic because each representative's understanding of what you should provide to prove your income was different. This, to your understanding, caused a large delay in your family having been found eligible for Medicaid.
- 12) You testified that you incurred medical expenses because your family's Medicaid coverage ended on January 31, 2017. You further testified that you were seeking a reinstatement of your family's Medicaid coverage as of February 1, 2017.

13)At the request of the Hearing Officer, on November 19, 2017, you provided a record of you and your spouse earnings and expenses during the month of April 2017.

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

Applicable Law and Regulations

Medicaid

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

MMC plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; see 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Verification Process

For 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)).

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)).

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

NYSOH must provide Medicaid applicants who are at least one year of age but younger than nineteen notices of their eligibility determination within 30 days of the date of the application if the household income does not exceed 138% of the federal poverty level (18 NYCRR §360-2.4(a)(3)(ii)).

Legal Analysis

The issue under review is whether NYSOH failed to provide you with a timely determination of eligibility after your January 14, 2017 application for Medicaid on behalf of yourself, your spouse, and your younger child.

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.

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.

You updated your NYSOH account on January 14, 2017. The income amount that was entered into this application did not match federal and state data sources, but did place you, your spouse, and your younger child into a "pending Medicaid" status. As a result, NYSOH asked that you submit additional documentation to confirm your income by January 29, 2017.

On February 12, 2017, you provided to NYSOH a spreadsheet reflecting your and your spouse's self-employment income and expenses for the period between November 18, 2015 and November 16, 2016. This document reflected a combined gross income of \$19,495.03 and combined expenses of \$7,152.74. While NYSOH confirmed that the income portion of these documents were acceptable because they were itemized by date received during 2016, the record of expenses was not itemized by date received during 2016. Accordingly, NYSOH properly requested additional documentation to confirm your eligibility, which were requested by March 15, 2017.

The record reflects that you provided additional sets of income documentation between March 14, 2017 and April 24, 2017. In each case, this documentation was determined not to be valid for confirming your proof of income because it was not a signed 2016 tax return or it did not represent three previous months of self-employment income and expenses. However, you credibly testified that NYSOH representatives told you to supply the income documentation for the months of January, February, and March 2017, which were not the correct months you needed to document.

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On May 10, 2017 that you and your spouse provided the separate earnings and expenses worksheets for the months of October, November, and December 2016, which correspond to the three previous months prior to your original January 14, 2017 application.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application for adults, and within 30 days for a child between the ages of one and nineteen whose income is at or below 138% of the FPL.

The Appeals Unit finds that NYSOH provided you with conflicting information on the documentation needed to confirm your household's eligibility, and it will be presumed that the documentation you ultimately provided on May 10, 2017 to complete your application submitted on January 14, 2017 would have been provided timely had you been given correct information.

Therefore, your family's enrollment in Medicaid start date for you, your spouse, and your youngest child should have been February 1, 2017. In any event, because NYSOH did not issue an eligibility determination finding you, your spouse, and your younger child eligible for Medicaid, effective May 1, 2017, NYSOH has failed to issue a timely eligibility determination following your January 14, 2017 application and subsequent efforts to provide the necessary documentation to complete your application.

The May 11, 2017 eligibility determination notice is MODIFIED to stated that the Medicaid coverage for you, your spouse, and your younger child begins effective February 1, 2017.

Decision

The May 11, 2017 eligibility determination notice is MODIFIED to stated that the Medicaid coverage for you, your spouse, and your younger child begins effective February 1, 2017.

Effective Date of this Decision: December 18, 2017

How this Decision Affects Your Eligibility

The Medicaid eligibility for you, your spouse, and your younger child is reinstated for the months of February, March and April 2017.

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).

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 case 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
- 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.

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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
PO Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The May 11, 2017 eligibility determination notice is MODIFIED to stated that the Medicaid coverage for you, your spouse, and your younger child begins effective February 1, 2017.

The Medicaid eligibility for you, your spouse, and your younger child is reinstated for the months of February, March and April 2017.

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، يرجى الاتصال بالرقم 1-855-355-5777. يمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

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।

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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&btumi ama wo obi a okyerε 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 איך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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