



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

Notice of Decision

Decision Date: May 15, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000026703

[REDACTED]

Dear [REDACTED]

On March 28, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 22, 2017 eligibility determination notice, the December 27, 2017 discontinuance notice, and the January 31, 2017 eligibility determination notice.

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.

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: May 15, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000026703



Issue

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

Did NY State of Health (NYSOH) properly determine you were not eligible for Medicaid for the months of November and December 2017?

Procedural History

On November 16, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on your behalf.

On November 17, 2017, NYSOH issued a notice stating the income information in your applications did not match information received from state and federal data sources. You were directed to submit proof of your income or NYSOH would not be able to determine your eligibility for health coverage. The notice included a "Documentation List" providing the types of documents accepted to prove various kinds of income. The list indicated that to prove wages, an applicant must submit paycheck stubs for the last four weeks or a letter from the employer. The list further stated that to prove unemployment benefit payments, an applicant must submit an award letter/ certificate, monthly benefit statements, a print out of the recipient's payment information from the NYS Department of Labor's website, or a copy of a Direct Payment Card with statement.

On November 22, 2017, NYSOH issued a notice stating the documentation received was insufficient to confirm the information in your application. You were directed to submit additional documentation of your income by December 16, 2017. That notice also included a "Documentation List."

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).

On December 26, 2017, NYSOH systematically redetermined your eligibility.

On December 27, 2017, NYSOH issued a notice stating you were not eligible to enroll in health coverage through NYSOH, because you did not provide the income documentation needed to verify the information in your application and, therefore, did not complete the requirements for obtaining Medicaid.

On January 3, 2018, you contacted NYSOH's Account Review Unit and requested an appeal insofar as you were not eligible for Medicaid.

On January 4, 2018, NYSOH received your updated application for financial assistance with health insurance requesting help paying for medical bills from the months of November and December 2017.

On January 6, 2018, NYSOH issued an eligibility determination notice, based on a January 5, 2018 systematic eligibility redetermination, stating you were conditionally eligible for Medicaid, effective January 1, 2018. That notice directed you to submit proof of benefit information for third-party health insurance by January 19, 2018.

On January 16, 2018, NYSOH issued an enrollment notice, based on your January 15, 2018 plan selection, confirming your enrollment in a Medicaid Managed Care plan, effective February 1, 2018.

On January 31, 2018, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective January 1, 2018.

Also on January 31, 2018, NYSOH issued a notice stating you were not eligible for retroactive Medicaid assistance for the months of November and December 2017, because the monthly income information you provided in your application was over the allowable limit to qualify for Medicaid.

On March 28, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed thereafter.

Findings of Fact

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

- 1) An updated application was submitted on your behalf on November 16, 2017 listing your annual expected income for 2017 as \$16,378.00, consisting of inconsistent income earned from two jobs in 2017 as well as eight weeks of unemployment insurance benefit payments of \$430.00.

- 2) According to your account, NYSOH was unable to verify the income information in your application and you were directed to submit proof of your income before NYSOH could determine your eligibility.
- 3) You testified that you received the November 17, 2017 notice requesting documentation of your income.
- 4) On November 18, 2017, you uploaded five biweekly paystubs to your NYSOH account as well as two offers of employment from [REDACTED] providing hourly rate information for the jobs being offered.
- 5) According to your account, on November 21, 2017, NYSOH invalidated your income documentation for not conforming with the documentation request. You were directed to submit additional documentation of your income.
- 6) You testified that you received the November 22, 2017 notice from NYSOH stating that the documentation you submitted was insufficient and requesting additional documentation of your income, but you disregarded that notice, because you had already sent documentation of your income.
- 7) According to your account, NYSOH systematically redetermined your eligibility on December 26, 2017, and found you ineligible to enroll in health coverage through NYSOH, purportedly because you did not provide sufficient documentation to verify the income information in your application.
- 8) You appealed insofar as you were not eligible for Medicaid.
- 9) You testified that you are contesting the November 17, 2017 notice and the December 27, 2017 notices insofar as you were not determined eligible for Medicaid for the months of November and December 2017.
- 10) You testified that from January 2017 through March 2017, you received severance payments from your prior job which totaled \$17,533.51. You testified that you did not include this information in your November 17, 2017 application, because you were no longer receiving those payments at the time you applied.
- 11) You testified that you also received unemployment insurance benefits in early 2017. You were not sure of how many weeks you received benefit payments for. You thought it might have been eight.
- 12) You testified that you worked for [REDACTED] from May to October 2017 and then you took a position in another location, still with [REDACTED], in October 2017 and that you are still working at that job.

- 13) On January 4, 2018, you submitted an updated application attesting to no expected income for 2018. The only income information provided in that application was inconsistent income earned from your employment between October 30, 2017 and December 31, 2017.
- 14) The January 4, 2018 application requested retroactive coverage for the months of November and December 2017, listing your monthly income as \$2,162.84 and \$2,175.00, respectively.
- 15) Also on January 4, 2018, you uploaded the following biweekly paystubs:
 - a. Pay date of November 23, 2017 in the gross amount of \$1,517.00.
 - b. Pay date of December 7, 2017 in the gross amount of \$1,526.00.
 - c. Pay date of December 21, 2017 in the gross amount of \$1,526.00
 - d. Pay date of January 4, 2018 in the gross amount of \$1,503.56.
- 16) According to your account, on January 5, 2018, NYSOH systematically redetermined your eligibility and found you conditionally eligible for Medicaid, effective January 1, 2018, pending receipt of documentation pertaining to third-party insurance benefits.
- 17) According to your account, you selected a Medicaid Managed Care plan on January 15, 2018 and coverage through that plan became effective on February 1, 2018.
- 18) On January 30, 2018, NYSOH systematically redetermined your January 4, 2018 request for retroactive coverage for the months of November and December 2017 and denied your request, based on the income information in your application.
- 19) You testified that you are appealing the denial of your request for retroactive Medicaid coverage for the months of November and December 2017 and the issue under appeal was amended accordingly.
- 20) Both your November 16, 2017 application and your January 4, 2018 application indicated that you would file your tax return with a tax filing status of single and you would claim no dependents. You testified that information was accurate.
- 21) You testified that you should have been determined eligible for Medicaid when you first applied on November 16, 2017, because your income was within the applicable range and you submitted proof of your income at that time.

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

Applicable Law and Regulations

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), 42 CFR § 435.945).

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) 42 CFR § 435.952).

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 2017 FPL, which is \$12,060.00 for a one-person household (81 Fed. Reg. 4036).

Retroactive Medicaid

The Department of Health must make Medicaid assistance available 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 properly determined you were not eligible for Medicaid for the months of November and December 2017.

On November 16, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on your behalf. That application listed your annual expected income for 2017 as \$16,378.00, consisting of inconsistent income earned from two jobs in 2017 as well as eight weeks of unemployment insurance benefit payments of \$430.00. According to your account, NYSOH was unable to verify the income information listed in that application and you were placed in a pending Medicaid status with documentation of your income requested. You testified that you are appealing insofar as you were not determined eligible for Medicaid, effective November 1, 2017, based on your November 16, 2017 application.

Pursuant to the above cited regulations, 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.

According to your account, NYSOH was unable to verify the income information listed in your application with state and federal data sources. As discussed above, your November 16, 2017 application attested to annual expected income for 2017 of \$16,378.00 consisting of inconsistent income earned from two jobs in 2017 as well as eight weeks of unemployment insurance benefit payments. However, at the hearing, you testified that between January and March 2017, you also received \$17,533.51 in severance payments from your prior job. These severance payments were not attested to in your application as part of your expected annual income for 2017. Your account further confirms that at the time of your November 16, 2017 application, you had not yet submitted any documentation of your 2017 income.

Therefore, the November 17, 2017 notice stating that the income information in your application did not match the information received from state and federal data sources and NYSOH was unable to determine your eligibility until you submitted sufficient proof of your income, was supported by the record as well as the regulations and, thus, that notice is AFFIRMED.

Your account confirms that on November 18, 2017, you uploaded five biweekly paystubs to your NYSOH account as well as two offers of employment from [REDACTED] providing hourly rate information for the jobs being offered. On November 21, 2017, NYSOH invalidated your income documentation for not conforming with the documentation request. Given your testimony that you received the

November 17, 2017 notice from NYSOH containing the “Documentation List” specifying the documentation you needed to submit if you received unemployment insurance benefits, it is concluded that NYSOH properly invalidated the documentation you submitted on November 18, 2017, because it contained no proof of the unemployment insurance benefits attested to in your application.

Although you testified that you received the November 22, 2017 notice from NYSOH advising you that the documentation you submitted was not sufficient to verify the information in your application and requesting additional documentation of your income by December 16, 2017, you further testified that you disregarded that notice, because you had already sent documentation of your income.

On December 26, 2017, NYSOH systematically redetermined your eligibility and found you ineligible to enroll in health coverage through NYSOH, purportedly because you did not provide sufficient documentation to verify the income information in your application. You appealed insofar as NYSOH did not find you eligible for Medicaid at that time. However, based on the evidence establishing that NYSOH could not verify the information in your November 16, 2017 application, that you were provided adequate notice of the documentation needed to verify the information in your application, and that you failed to submit sufficient documentation of your 2017 income by the deadline provided, it is concluded that NYSOH properly determined you were ineligible for health insurance, based on the lack of reliable evidence of your 2017 income.

Therefore, the December 27, 2017 notice stating you were ineligible for health insurance through NYSOH, because you did not provide income documentation needed to verify the income information in your application, was correct and is **AFFIRMED**.

You subsequently updated your application on January 4, 2018. It is noted that the January 4, 2018 application attested to no income for 2018, rather the only income listed was \$5,744.00 you attested to receiving inconsistent income for the time-period of October 30, 2017 and December 31, 2017. Also on January 4, 2018, you uploaded four biweekly paystubs, one with a pay date of November 23, 2017 showing gross income of \$1,517.00, two for pay dates in December 2017 showing gross income of \$1,526.00 and \$1,526.00, and one with a pay date of January 4, 2018 showing gross income of \$1,503.56. Notwithstanding the documentation of your current income, NYSOH inexplicably redetermined your eligibility based on an annual expected income for 2018 of \$5,744.00 and found you eligible for Medicaid, effective January 1, 2018.

It is noted that the January 4, 2018 application requested retroactive coverage for the months of November and December 2017, listing your monthly income as \$2,162.84 and \$2,175.00, respectively. Subsequently, NYSOH denied your request, on the grounds that the monthly income amounts attested to exceed the

income limit to qualify you for Medicaid in those months. You testified you are appealing the denial of your request for retroactive Medicaid.

Although the January 31, 2018 denial of retroactive Medicaid assistance for the months of November and December 2017 were properly based on the income information you attested to in your January 4, 2018 application, it is concluded that the record contains documentary evidence of your income in those months, thus, the Appeals Unit will review your eligibility based on that evidence.

Pursuant to the regulations, when an individual file an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Pursuant to the regulations, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

To be eligible for Medicaid in November and December of 2017, you would have needed to meet the non-financial criteria and have a household income no greater than 138% of the applicable FPL. The evidence establishes that you are in a one-person household, because you file your tax returns with a filing status of single and you claim no dependents. The applicable FPL for a one-person household in 2017 was \$12,060.00. Therefore, to qualify for Medicaid in November and December 2017, your monthly income could not exceed \$1,387.00, 138% of the applicable monthly FPL.

Since the record establishes that you received, at least, \$1,517.00 in income in the month of November 2017, based on the November 23, 2017 paystub, over \$1,387.00 limit, you did not qualify for Medicaid for the month of November 2017 based on your monthly income. Furthermore, you submitted two paystubs for the month of December 2017 showing combined monthly gross income of \$3,052.00. Since your monthly income for the month of December 2017 exceeded the monthly income limit, you were not eligible for Medicaid in that month based on your monthly income.

Therefore, the January 31, 2018 notice stating you were not eligible for retroactive Medicaid assistance for the months of November and December 2017, is supported by the record and; thus, is AFFIRMED.

Decision

The November 17, 2017 eligibility determination notice is AFFIRMED.

The December 26, 2017 discontinuance notice is AFFIRMED.

The January 31, 2017 notice denying your request for retroactive Medicaid assistance for November and December 2017 is AFFIRMED.

Effective Date of this Decision: May 15, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

You were not eligible for coverage through NYSOH in the months of November or December 2017.

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 a portion of 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

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).

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

Summary

The November 17, 2017 eligibility determination notice is AFFIRMED.

The December 26, 2017 discontinuance notice is AFFIRMED.

The January 31, 2017 notice denying your request for retroactive Medicaid assistance for November and December 2017 is AFFIRMED.

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).

This decision does not change your eligibility.

You were not eligible for coverage through NYSOH in the months of November or December 2017.

Legal Authority

We are sending you this notice 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।

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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. y&b&tumi ama wo obi a okyerE 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 דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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