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

Notice of Decision

Decision Date: May 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014901

[redacted]

Dear [redacted],

On April 11, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's determination that you were eligible for presumptive Medicaid coverage for the month of September 2016.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: May 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014901

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you were eligible for presumptive Medicaid coverage only and not full Medicaid coverage for the month of September 2016?

Procedural History

On April 26, 2016, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid, effective May 1, 2016. The notice further stated that you must provide proof of your income before May 10, 2016.

On June 5, 2016, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid; however, your Medicaid coverage would continue until March 31, 2017.

On September 14, 2016, September 22, 2016, October 14, 2016, and November 9, 2016, NYSOH issued eligibility determination notices, based on your September 13, 2016 September 21, 2016, October 13, 2016, and November 8, 2016 updated applications, stating that you were no longer eligible for Medicaid; however, your Medicaid coverage would continue until March 31, 2017. The reason stated for you no longer being eligible for Medicaid was because the household income you provided was over the allowable income limit for that program.

On January 17, 2017, you spoke to NYSOH's Account Review Unit and appealed not being determined eligible for full Medicaid for the month of September 2016.

On January 18, 2017, NYSOH issued an appeal notice stating that you appealed your "Eligibility determination and Other: Appealing the presumptive coverage for September 2016, requesting full Medicaid."

On April 11, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open until April 26, 2017 for you to submit proof of your household income for 2016 and September 2016; specifically, your spouse's 2016 income tax return and proof of all paystubs and payments he received in that month.

As of April 26, 2017, the Appeals Unit had not received any of these documents from you nor were they visible in your NYSOH account. Therefore, the record was closed that day and this decision is based on the record as developed at the time of hearing

Findings of Fact

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

1) According to your NYSOH account, you updated your application for health insurance on April 25, 2016, and were found conditionally eligible for Medicaid pending proof of your household income.

2) According to your NYSOH account and your testimony, you do not plan on filing your 2016 income taxes, and your spouse filed his 2016 federal income tax return as married filing single and claimed two dependents. You testified that you reside with your spouse and your two children.

3) According to the April 25, 2016 application, you attested to an expected annual household income of $47,000.00. You testified that this income was correct at that time.

4) You testified that you were not notified that you would only be covered for "outpatient services" with the form of Medicaid you were given.

5) Official notice is taken that you had Medicaid on a conditional basis; that is, in what is known as "presumptive Medicaid," under which certain labor and deliver charges, as well as related hospital charges, will not be covered by the Medicaid program.

6) You testified that you did not receive NYSOH's April 26, 2016 eligibility determination notice stating that you needed to provide proof of income to confirm your eligibility.

7) According to your NYSOH account and your testimony, you receive all your notices from NYSOH via regular mail.

8) According to your NYSOH account, on January 17, 2017, you spoke to NYSOH's Account Review Unit and appealed not being determined eligible for full Medicaid benefits during the month of September 2016.

9) According to an eMedNY report dated May 12, 2017, you were at all times between May 1, 2016 and January 31, 2017 eligible for and enrolled in presumptive eligibility Medicaid.

10) You testified that the Medicaid coverage you had does not cover certain labor, delivery, hospitalization and doctor's charges related to the birth and hospitalization of your [redacted] in September 2016, and you want to appeal those charges not being covered.

11) You testified that you are only seeking full Medicaid for yourself in the month of September 2016 because your [redacted] was covered by your spouse's employer-sponsored health coverage.

12) The record was held open by the Hearing Officer until April 26, 2017 to allow you to submit proof of income for the year 2016 and for September 2016; specifically, you were directed to submit your spouse's 2016 income tax return and proof of all paystubs and payments he received in the month of September 2016. You did not submit the documentation.

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

Applicable Law and Regulations

De Novo Review

The Marketplace Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

Medicaid for Pregnant Women

Medicaid can be provided through the Marketplace 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)), N.Y. Soc. Serv. Law § 366(1)(b)).

In New York, a pregnant woman is eligible for Medicaid at a household income of 223% of the federal poverty level (FPL) for the applicable family size (42 CFR §435.116 (c)(2); NY Department of Social Services Administrative Directive 13ADM-03).

“Family size” means the number of persons counted as members of an individual’s household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

For purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

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 January 15, 2016 application under review, that was the 2015 FPL, which is $28,410.00 for a five-person household (80 Fed. Reg. 3236, 3237).

Generally, Medicaid coverage begins on the first day of the month in which the applicant was found eligible (42 CFR § 435.915(b)).

Pregnant Women/Newborn Medicaid Eligibility

Pregnant women who meet the non-financial and financial criteria for Medicaid eligibility for any month during her pregnancy is guaranteed Medicaid eligibility until the end of the month in which the 60th day occurs after the pregnancy ends. This eligibility remains regardless of any changes in household income. Infants born to women during their period of guaranteed eligibility are eligible until the end of the month in which the 60th day occurs after the birth, without regard to changes in household income (42 CFR § 435.116; SSA § 1902(a)(10); SSA § 1905(n); NY Social Services Law § 366(4)(b)) .

Legal Analysis

Initially, it is noted that you updated your account and applied for Medicaid for yourself on April 25, 2016. On April 26, 2016, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid, effective May 1, 2016. The notice further stated that you must provide proof of your income before May 10, 2016 for NYSOH to confirm your eligibility for full Medicaid benefits.

Although the record contains an April 26, 2016 eligibility determination notice on the issue of Medicaid eligibility for May 2016, it is silent as to your request for full Medicaid to cover your hospital bills for labor and delivery of your child in September 2016. The record does contain a January 17, 2017 telephone call to NYSOH in which you requested a full coverage Medicaid to cover outstanding bills you have from September 2016 and a January 18, 2017 notice in which NYSOH acknowledges receipt of an appeal request, and identifies you as the appellant and the issue on appeal as "Eligibility determination and Other: Appealing the presumptive coverage for September 2016, requesting full Medicaid."

Here, the lack of a notice of eligibility determination on the issue of full Medicaid for you for the month of June 2016 does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The text of the January 18, 2017 notice, which acknowledges the appeal on the issue of your eligibility, along with the record of the January 17, 2017 telephone call made to NYSOH, in which you stated you wanted help covering the medical expenses you had for the month of September 2016, permits an inference that the NYSOH had not determined your request for full Medicaid for yourself for the month of September 2016.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to an eligibility determination had it been issued. Therefore, the issue under review is whether NYSOH properly determined that you were only presumptively eligible for Medicaid coverage and not for full Medicaid benefits for the month of September 2016.

You testified that your newborn was covered through your spouse's employer-sponsored health coverage and coverage for the newborn is not in dispute. According to your NYSOH account, you were presumptively eligible for Medicaid for the months of May 2016 through January 2017. As has been officially noted above, presumptive Medicaid does not cover certain labor and delivery charges nor related hospital charges.

You testified that you are seeking “full” Medicaid coverage for yourself only so that labor and delivery charges and hospitalization charges related to your child’s birth can be covered.

The record reflects that, on April 25, 2016, you submitted your updated application for financial assistance and were found presumptively eligible for Medicaid, pending verification of your household income.

In cases of presumptive eligibility, full Medicaid benefits can be made effective from the first day of the month that an individual is found fully eligible for Medicaid. However, you were never found fully eligible for Medicaid by NYSOH because you did not submit any proof of your household income. Thus, your eligibility for full Medicaid could not be determined on a financial basis and your presumptive eligibility status was never changed to full Medicaid status.

You testified that you were unaware that you needed to provide proof of income to confirm your eligibility because you never received NYSOH’s April 26, 2016 notice stating that you were supposed to do so. However, this argument is not persuasive since, according to your NYSOH account, you receive all your notices, including the April 26, 2016 notice, from NYSOH by regular mail and none of those notices have been returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you that proof of income was required for you to confirm your eligibility for “full” Medicaid.

Even though you had not provided proof of your household’s income to NYSOH, the record was held open until April 26, 2017 for you to submit proof of income for 2016 and for September 2016. Specifically, the Hearing officer directed you to submit your spouse’s 2016 income tax return and proof of all paystubs and payments he received in that month. Since you did not submit the documentation, this decision is based on the record as developed at the time of hearing.

Since you failed to submit proof of household income for 2016 or any of the month’s you were deemed presumptively eligible, that is from May 1, 2016 through January 2017, we cannot reach the merits of whether you would have been eligible for “full” Medicaid benefit either on an annual or monthly basis.

Since the April 26, 2016 eligibility determination notice properly found you presumptively eligible for Medicaid effective May 1, 2016, it remains correct and must be AFFIRMED.

Therefore, it follows that the subsequently issued eligibility determination notices dated September 14, 2016, September 22, 2016, October 14, 2016, and November 9, 2016, were correct and must be AFFIRMED.

Decision

The April 26, 2016 eligibility determination notice properly found you presumptively eligible for Medicaid effective May 1, 2016, and remains correct and must be AFFIRMED.

It follows that the subsequently issued eligibility determination notices dated September 14, 2016, September 22, 2016, October 14, 2016, and November 9, 2016 were correct and must be AFFIRMED.

This Decision has no effect on any subsequent eligibility determination or enrollment notices issued by NYSOH.

Effective Date of this Decision: May 17, 2017

How this Decision Affects Your Eligibility

Your eligibility for Medicaid benefits during September 2016 was presumptive only.

You were not eligible for "full" Medicaid benefits for the month of September 2016.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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

The April 26, 2016 eligibility determination notice properly found you presumptively eligible for Medicaid effective May 1, 2016, and remains correct and must be AFFIRMED.

It follows that the subsequently issued eligibility determination notices dated September 14, 2016, September 22, 2016, October 14, 2016, and November 9, 2016 were correct and must be AFFIRMED.

This Decision has no effect on any subsequent eligibility determination or enrollment notices issued by NYSOH.

Your eligibility for Medicaid benefits during September 2016 was presumptive only.

You were not eligible for “full” Medicaid benefits for the month of September 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[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 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 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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