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

Notice of Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015817

[redacted]

Dear [redacted],

On May 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 5, 2017 eligibility determination notice insofar as you were denied full Medicaid coverage during the month of February 2017.

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

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

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

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

Legal Authority

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

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

This page intentionally left blank.

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).

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

Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015817

[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 not eligible for full Medicaid coverage for the month of February 2017?

Procedural History

On February 24, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective February 1, 2016. You enrolled in a Medicaid Managed Care (MMC) plan on that same date, with such coverage to begin effective April 1, 2016.

On December 3, 2016, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that based on information from federal and state sources, NYSOH could not determine whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by January 15, 2017 or you might lose the financial assistance you were currently receiving.

On January 4, 2017, NYSOH received an update to your application for health insurance, which reflected that you were pregnant with one child.

On January 5, 2017, NYSOH issued an eligibility determination notice based on the information contained in the January 4, 2017 application. The notice stated that you were conditionally eligible for Medicaid, effective February 1, 2017. You were requested to provide income documentation by January 19, 2017. The

notice cautioned that failure to provide the requested documentation by the due date may result in a loss of insurance or less financial assistance. You were also advised in this notice to select an MMC plan.

Also on January 5, 2017, NYSOH issued an eligibility determination notice confirming that your MMC plan coverage would end effective January 31, 2017. This was because you are no longer eligible to remain enrolled in that MMC. The notice advised you to log into you NYSOH account and select a new MMC plan.

On January 30, 2017, NYSOH redetermined your eligibility for health insurance.

On January 31, 2017, NYSOH issued an eligibility redetermination notice stating that you were found newly eligibility to purchase a qualified health plan at full cost through NYSOH, effective March 1, 2017. You were found ineligible for Medicaid because NYSOH had not received the requested income documentation to verify your income by the due date.

On February 6, 2017, NYSOH received an updated application for health insurance.

On February 7, 2017, NYSOH issued an eligibility redetermination notice based on the information contained in the February 6, 2017 application. The notice stated that you were eligible for an advance premium tax credit (APTC) of up to $507.00 per month and cost-sharing reductions (CSR), in each case for a limited time, effective March 1, 2017.

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

On February 17, 2017, NYSOH issued an enrollment notice confirming your selection of a silver-level QHP as of February 16, 2017, the notice stated that your coverage would begin effective February 1, 2017.

On May 16, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) Your NYSOH account reflects that at the time of your household's January 4, 2017 application update, you and your spouse resided together with your three children, and you were pregnant with one child with an expected due date of [redacted].

2) Your NYSOH account reflects that your newborn child was born on [redacted].

3) You testified, and your NYSOH account reflects, that because of your application update on January 4, 2017, you were found conditionally eligible for Medicaid, effective February 1, 2017. You were requested to provide income documentation by January 19, 2017.

4) Your NYSOH account indicates that you receive notices from NYSOH by regular mail.

5) You testified that you did not receive any notices from NYSOH telling you that you needed to provide additional income documentation to confirm your eligibility for Medicaid.

6) No notices sent to you at the address listed on your NYSOH account have been returned as undeliverable.

7) You testified that after your updated your account over the phone with a NYSOH representative on January 4, 2017, the NYSOH representative stated that you were now covered under Medicaid and did not need to take any further action.

8) You testified that you were seeking to be found eligible for full Medicaid benefits, rather than presumptive benefits, during the month of February 2017 so that the approximate $30,000.00 in medical expenses related to the [redacted] can be covered.

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

Applicable Law and Regulations

De Novo Review

NYSOH's 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).

Household Composition

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a per child who is in the family of a pregnant woman includes not only

the pregnant woman, but also 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).

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 federal poverty level (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 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 tax 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)).

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 May 29, 2016 application, that was the 2016 FPL, which is $20,160.00 for a three-person household (81 Federal Register 4036).

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

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for full Medicaid coverage for the month of February 2017.

The record contains no indication that NYSOH issued any notice that addresses your request to have you found eligible for full Medicaid coverage during the month of February 2017.

Here, the lack of a notice of eligibility determination on the issue of full Medicaid benefits for you during the month of February 2017 does not prevent the Appeals

Unit from reaching the merits of the case. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH's failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

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 refined to whether you were properly denied full Medicaid benefits for the month of February 2017.

According to your NYSOH account and your testimony, as of your January 4, 2017 application, you expected to file your 2017 taxes with a tax filing status of married filing jointly and to claim three dependents on that tax return. When determining eligibility for Medicaid, the household of a pregnant woman includes not only the pregnant woman, but also the number of children she is expected to deliver. Since you were pregnant in January 2017 with one child, your household size, for purposes of this analysis, was a six-person household.

Your NYSOH account reflects that you had presumptive Medicaid during February 2017, which does not cover labor and delivery charges. You testified that you are seeking to have your Medicaid coverage changed to "full" Medicaid coverage during that month when you gave birth, so that the [redacted] related to your child's birth can be covered.

You were found conditionally eligible for Medicaid in the notice dated January 5, 2017. In that eligibility determination notice, you were advised that you were conditionally eligible for Medicaid, and that you needed to confirm your household's income before January 19, 2017. Since income documentation was not received by NYSOH following that eligibility determinations, your coverage remained presumptive.

You testified that you did not receive any notice from NYSOH telling you that you needed to provide income documentation to confirm your eligibility. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, NYSOH properly notified you of an inconsistency in your account and that documentation was needed to confirm the income you listed in the account.

If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine an individual's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation.

Accordingly, your eligibility for conditional Medicaid terminated as of February 28, 2017, because you did not submit documentation and did not adequately

demonstrate that you could not provide documentation to confirm your income. Accordingly, your Medicaid enrollment appropriately remained “presumptive.”

Therefore, the January 5, 2017 eligibility determination notice, insofar as you were denied full Medicaid coverage during the month of February 2017, is AFFIRMED.

Decision

The January 5, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: June 28, 2017

How this Decision Affects Your Eligibility

You remain eligible for presumptive Medicaid benefits during the month of February 2017.

If You Disagree with this Decision (Appeal Rights)

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

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

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

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

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace

Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061

- By fax: 1-877-369-0129

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

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

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The January 5, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for presumptive Medicaid benefits during the month of February 2017.

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.

□□□□□ (Bengali)

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).

□□□ □□ □□□□□□□□□□□□□ □□□□ □□□ □□□□□ □□□□□ □□□ □□□□□□□□□□ □□□□□□□□ □□ □□□□□,
□□□□□□□□ □□□ 1-855-355-5777 □□□□□□□ □□ □□□□□ □□□□ □□ □□□□□□□ □□□ □□□□
□□□□□□□□□□□ □□□□ □□□□□□□ □□□□ □□□□□□□ □□□□ □□□□□

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)

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).

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.

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).