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

Notice of Decision

Decision Date: October 4, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018951

[redacted]

Dear [redacted],

On August 16, 2017, you appeared by telephone at a hearing based on your request for retroactive Medicaid benefits for the month of March 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).

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Decision

Decision Date: October 4, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018951

[redacted]

Issue

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

> Should NY State of Health (NYSOH) have determined you, [redacted] eligible for retroactive Medicaid coverage for the month of March 2017?

Procedural History

On February 15, 2017, NYSOH redetermined your eligibility.

On February 16, 2017, NYSOH issued an eligibility determination stating that you were conditionally eligible to purchase a qualified health plan at full cost, effective March 1, 2017. The notice directed you to provide proof of citizenship status by May 9, 2017.

On February 26, 2017, NYSOH issued a notice of enrollment confirmation advising you to select a health plan.

Your child was born on [redacted]

On March 7, 2017, you updated your NYSOH account.

On March 8, 2017, NYSOH issued an eligibility notice stating that your child was eligible for Medicaid effective March 1, 2017. The notice directed that you provide proof of income by March 12, 2017.

Also on March 8, 2017, NYSOH issued an enrollment confirmation notice stating that your child was enrolled in a Medicaid Managed Care plan, effective April 1, 2017.

Also on March 8, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal sources. You were directed to provide income documentation by March 22, 2017.

On April 4, 2017, you updated your household's application for financial assistance and indicated that you were seeking help paying for past medical bills.

On April 5, 2017, NYSOH issued an eligibility determination notice stating that your child remained eligible for Medicaid, effective March 1, 2017. You were directed to provide income documentation for [redacted] by April 6, 2017 and for [redacted] by April 19, 2017.

Also on April 5, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal sources. You were directed to provide income documentation by April 6, 2017 and April 19, 2017.

On April 27, 2017, NYSOH issued a notice stating that the documentation provided did not confirm the information in your application. You were directed to provide proof of income by May 19, 2017.

On May 10, 2017, you uploaded to your NYSOH account a letter dated May 9, 2017, in which you requested Retroactive Medicaid coverage for the month of March 2017 to help pay for [redacted], [redacted], [redacted], and [redacted], received during March 2017.

Also, on May 10, 2017, NYSOH redetermined your eligibility.

On May 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan, effective June 1, 2017.

On May 16, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in an Essential Plan, effective June 1, 2017.

On May 15, 2017, you spoke to NYSOH's Account Review Unit and requested Retroactive Medicaid benefits for the month of March 2017 to cover the medical expenses related to the delivery of your newborn child.

On August 16, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was left open until September 1, 2017 to allow you to submit supporting documentation.

On August 18, 2017, the Appeals Unit received copies of your spouse's paystubs, your statement of disability benefits, and a disability payout letter. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

Findings of Fact

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

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

2) On April 4, 2017, you updated your application to request help for the payment of past medical bills.

3) On May 10, 2017, you uploaded to your NYSOH account a letter dated May 9, 2017, in which you requested Retroactive Medicaid coverage for the month of March 2017 to help pay for [redacted], [redacted], [redacted], and [redacted], received during March 2017.

4) No eligibility determination has been issued to date regarding your request for retroactive Medicaid coverage for the month of March 2017.

5) You[redacted] testified that during the month of March 2017 your only income was from disability payments you were receiving.

6) You testified that your spouse is paid weekly.

7) On August 18, 2017, you faxed copies of five of your spouse's paystubs to the NYSOH appeals unit. The first is for pay date March 10, 2017 for a gross pay amount of $263.38; the second is for pay date March 17, 2017 for a gross pay amount of $387.00; the third is for pay date March 24, 2017 for a gross pay amount of $319.81; the fourth is for pay date March 31, 2017 for a gross pay amount of $387.00; and the fifth is for pay date April 7, 2017 for a gross pay amount of $387.00.

8) The year-to-date total listed on the March 10, 2017 pay stub was $2,993.89.

9) You did not provide a pay stub for your spouse for the pay date of March 3, 2017 (there were five Fridays in March 2017).

10) You provided an explanation of disability benefits which stated that you received a check in the amount of $453.83 on March 7, 2017 for the disability period of February 13, 2017 through March 5, 2017. You also provided an explanation of disability benefits which stated that you

received a check in the amount of $857.24 on March 23, 2017 for the disability period of March 6, 2017 through April 13, 2017. You testified this was all the income you, [redacted] received in March 2017.

11) You testified that you are seeking Retroactive Medicaid coverage for the month of March 2017 to assist with the extensive medical bills you incurred related to the birth of your child.

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 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 person 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 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).

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). In the month during which you are seeking retroactive coverage, that was the 2017 FPL, which is $20,420.00 for a three-person household (81 Federal Register 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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)).

Presumptive Eligibility for Pregnant Women

In New York State, presumptive eligibility for Medicaid is a means of immediately providing Medicaid coverage for prenatal care services pending a full Medicaid eligibility determination. A pregnant woman does not need to provide documentation of income for the presumptive eligibility determination. Pregnant women are also not required to document citizenship/immigration status for presumptive eligibility or for ongoing Medicaid eligibility. Citizenship/immigration status is not an eligibility requirement for a pregnant woman throughout her pregnancy and for two months after the month in which the pregnancy ends (N.Y. Social Services Law § 366 (4)(b)). Medicaid pays providers during the presumptive eligibility period for care provided to pregnant women; however, as a matter of Medicaid Program policy, labor and delivery services are excluded from payment.

Legal Analysis

The issue under review is whether you were eligible for retroactive Medicaid for the month of March 2017.

You testified that you are appealing the denial of retroactive Medicaid for the month of March 2017. You uploaded a letter dated May 9, 2017 where you request Retroactive Medicaid coverage for the month of March 2017 to help pay for [redacted], [redacted], [redacted], and [redacted] received during

March 2017. However, the record does not contain a notice of eligibility determination or redetermination on the issue of retroactive Medicaid.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid 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'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 the eligibility determination notice had it been issued.

The record reflects that you file your taxes with a tax filing status of married filing jointly.

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person 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. Therefore, for the purposes of Medicaid coverage, in March 2017 you were part of a three-person household, both before and after your child was born.

You submitted an application for financial assistance on April 4, 2017 requesting help in paying for medical bills for the three months preceding April 2017. However, you testified and your May 9, 2017 letter indicate that you are requesting retroactive Medicaid coverage only for the month of March 2017.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. It does not matter whether that initial application resulted in Medicaid going forward. Instead, any 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.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if the individual would have been eligible for Medicaid in those three months had he or she applied.

You testified that you are seeking Medicaid from March 1, 2017 to March 31, 2017 to assist with medical bills related to the birth of your child.

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 March 2017, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which was $3,794.72 per month in 2017. There is no indication in the record that

you would not have been eligible for Medicaid based on any non-financial criteria during March 2017.

You testified that your spouse was employed in March 2017 and that he was paid on a weekly basis. The Hearing Officer directed you to submit your spouse's paystubs for pay dates in March 2017. You provided four pay stubs: the first is for pay date March 10, 2017 for a gross pay amount of $263.38; the second is for pay date March 17, 2017 for a gross pay amount of $387.00; the third is for pay date March 24, 2017 for a gross pay amount of $319.81; the fourth is for pay date March 31, 2017 for a gross pay amount of $387.00. You did not provide a pay stub for your spouse for the pay date of March 3, 2017 (there were five Fridays in March 2017).

Total earnings in 2017 as of March 10, 2017, less $263.38 for pay received that day, equal $2,730.51. Divided over the nine preceding Fridays, that equals an average weekly pay of $303.39. However, the highest single gross pay documented was $387.00.

The Appeals Unit finds that using your spouse's highest gross weekly pay amount, or $387.00, to estimate the March 3, 2017 earnings, would be appropriate. As such, a reasonable estimate of your spouse earnings in March 2017 is $1,744.19.

You [redacted] testified that your only income during March 2017 were disability benefit payments you received. You provided an explanation of disability benefits which stated that you received a check in the amount of $453.83 on March 7, 2017 for the disability period of February 13, 2017 through March 5, 2017. You also provided an explanation of disability benefits which stated that you received a check in the amount of $857.24 on March 23, 2017 for the disability period of March 6, 2017 through April 13, 2017. You testified that this was the only income earned by you during March 2017. The record reflects that your total income received in the month of March 2017 was $1,311.07.

Therefore, the Appeals Unit finds that your household's gross monthly income for March 2017 was $3,055.26.

Since the record now contains a more accurate representation of what your household's income was for the month of March 2017, your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage from March 1, 2017 through March 31, 2017 based on a household size of three persons and household income of $3,055.26 for the month of March 2017.

Decision

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for a pregnant woman from March 1, 2017 through March 31,

2017 based on a household size of three persons and household income of $3,055.26 for the month of March 2017.

Effective Date of this Decision: October 4, 2017

How this Decision Affects Your Eligibility

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage from March 1, 2017 through March 31, 2017 for a pregnant woman based on a household size of three persons and household income of $3,055.26 for the month of March 2017.

This is not a final determination of your eligibility for retroactive Medicaid for the month of March 2017. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing. NYSOH will notify you once a redetermination is made.

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

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage from March 1, 2017 through March 31, 2017 for a pregnant woman based on a household size of three persons and household income of $3,055.26 for the month of March 2017.

This is not a final determination of your eligibility for retroactive Medicaid for the month of March 2017. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing. NYSOH will notify you once a redetermination is made.

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.

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).

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।

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 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.

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).

(Yiddish) אידיש

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).