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

Notice of Decision

Decision Date: January 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022106

[redacted]

Dear [redacted]

On November 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 22, 2017 eligibility determination notice insofar as you were not eligible for full Medicaid coverage during the month of June 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
  PO Box 11729
  Albany, NY 12211

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

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

Legal Authority

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

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

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
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Decision

Decision Date: January 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022106

[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 during the month of June 2017?

Procedural History

On May 5, 2017, NYSOH received your initial application for financial assistance with health insurance.

Also on May 5, 2017, NYSOH received an earnings statement issued to you by your employer, [redacted] on April 28, 2017.

On May 6, 2017, NYSOH issued an eligibility determination notice stating that you remained conditionally eligible for Medicaid, effective May 1, 2017. You were requested to provide income documentation by May 20, 2017 to confirm your eligibility.

Also on May 6, 2017, NYSOH issued an enrollment notice stating that the type of Medicaid coverage you are eligible for does not require or allow you to enroll in a Medicaid Managed Care (MMC) plan.

On May 12, 2017, NYSOH received an additional earnings statement issued to you by Pinnacle on May 12, 2017.

On May 30, 2017, NYSOH received an earnings statement issued to your spouse by his employer, [redacted] on May 24, 2017.

In response to the income documentation you provided to NYSOH between May 5, 2017 and May 30, 2017, NYSOH issued three separate notices, on May 9, 2017, May 16, 2017 and May 31, 2017, each stating that the income documentation you provided did not confirm the information contained within your application. In each case, you were requested to provide additional income documentation by June 4, 2017 to confirm your eligibility.

On June 15, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

Also on June 15, 2017, your NYSOH account details reflect that your conditional Medicaid enrollment ended effective June 30, 2017.

On June 16, 2017, NYSOH issued an eligibility determination notice stating that you were found eligible to enroll in a qualified health plan (QHP) at full cost, effective July 1, 2017. The notice further stated that you were not eligible for Medicaid because NYSOH did not receive the requested information to verify your income by the due date.

On June 16, 2017, NYSOH received an update to your application for financial assistance with health insurance.

Also on June 16, 2017, NYSOH received two earnings statements issued to your spouse by [redacted] on May 31, 2017 and June 14, 2017.

On June 17, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On June 18, 2017, NYSOH issued an eligibility determination notice stating that based on the information contained in the June 16, 2017 application, you had been found conditionally eligible for Medicaid, effective July 1, 2017.

Also on June 18, 2017, NYSOH issued an eligibility determination notice stating that based on the information contained in the June 17, 2017 application, you remained conditionally eligible for Medicaid, effective July 1, 2017.

Finally, on June 18, 2017, NYSOH received four earnings statements issued to your spouse by [redacted] between May 24, 2017 and June 14, 2017.

On June 19, 2017, NYSOH received a letter issued by [redacted] dated June 16, 2017, confirming that you were employed by that organization from December 22, 2014 to August 19, 2016, and you were no longer receiving health insurance from them.

Also on June 19, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

On June 20, 2017, NYSOH issued an eligibility determination notice stating that based on the information contained in your June 19, 2017 application, you remained eligible for Medicaid, without condition, effective July 1, 2017. The notice further stated that you the type of Medicaid coverage you are eligible for did not require or allow you to enroll in a health plan.

On June 21, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

On June 22, 2017, NYSOH issued an eligibility determination notice stating that based on the information contained in your June 19, 2017 application, you were eligible for Medicaid, without condition, effective July 1, 2017. The notice further advised you to select a health plan.

On June 23, 2017, NYSOH issued an enrollment notice confirming your selection of an MMC plan for your coverage as of June 22, 2017. The notice stated that your coverage under this MMC plan would begin effective August 1, 2017.

On September 5, 2017, you spoke to NYSOH's Account Review Unit and appealed the fact that you were not found eligible for full Medicaid benefits for the month of June 2017.

On November 30, 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 support the following findings of fact:

1) According to your NYSOH account, you were found conditionally eligible for Medicaid as of May 1, 2017 pending submission of household income documentation.

2) According to your NYSOH account, you provided income documentation on May 5, 2017, May 12, 2017, and May 30, 2017, which consisted of earnings statements issued to you and your spouse.

3) NYSOH records reflect that on May 9, 2017, May 16, 2017, and May 31, 2017, NYSOH deemed each of these submissions of proof of income as invalid as you and your spouse submitted less than the four weeks of earnings statements required to confirm your eligibility.

4) Your NYSOH enrollment details reflect that your presumptive eligibility, which began on May 1, 2017, ended on June 30, 2017 due to failure to provide the required income documentation by the June 4, 2017 deadline.

5) On June 18, 2017 and June 20, 2017, you provided several sets of earnings statements issued to you and your spouse during the months of May and June 2017, as well as a letter from your prior employer confirming that you were not enrolled in an employer-sponsored health insurance plan as of August 19, 2016.

6) Your NYSOH account reflects that your eligibility was redetermined on June 20, 2017, and you were found eligible for Medicaid coverage, without condition, effective July 1, 2017.

7) Your child was born on [redacted].

8) You testified that based on only having had presumptive coverage during the month of June 2017, you incurred significant medical bills from the birth of your child.

9) You testified that you were seeking "full" Medicaid eligibility during the month of June 2017, so that the bills incurred by you during that time could be paid and/or reimbursed.

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

Applicable Law and Regulations

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 June 20, 2017 application, that was the 2017 FPL, which is $20,420.00 for a three-person household (82 Federal Register 8831).

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 June 2017.

According to your NYSOH account and your testimony, based on your May 5, 2017 application, you were found eligible for Medicaid on a conditional basis, pending receipt of additional income documentation, effective May 1, 2017. This presumptive Medicaid eligibility continued until June 30, 2017, when it was terminated after NYSOH did not receive the necessary income documentation by the June 4, 2017 deadline.

The record reflects that you updated your account and applied for financial assistance for yourself and your spouse on June 17, 2017. On June 18, 2017, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid, pending proof of household income, effective July 1, 2017. Though you testified that you submitted income documentation and proof that you were no longer enrolled in coverage outside NYSOH as of August 19, 2016.

Your NYSOH account reflects that you had presumptive Medicaid during June 2017, which does not cover labor and delivery charges. You testified, and your NYSOH account reflects, that your child was born on [redacted]. You testified that you want your Medicaid coverage changed to “full” Medicaid

coverage during the month when you gave birth, so that the labor and delivery charges related to your child's birth can be covered.

Based on the documentation you provided on June 18, 2017 and June 20, 2017, your NYSOH account reflects that your eligibility was redetermined on June 21, 2017. NYSOH then issued an eligibility determination notice on June 22, 2017 stating that you were found eligible for Medicaid, without condition, effective July 1, 2017.

Because you were pregnant, to be eligible for full Medicaid during the month of June 2017, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the 2017 FPL, which is $45,536.60 for the year, or $3,747.00 per month for a three-person household. There is no indication in the record that you would have been ineligible for Medicaid based on any non-financial criteria during the month of June 2017. Therefore, the analysis turns to the financial requirements of Medicaid.

On June 18, 2017, you uploaded earnings statements issued to you and your spouse, which resulted in an eligibility determination finding you eligible for full Medicaid benefits, effective July 1, 2017. Generally, Medicaid coverage begins on the first day of the month in which the applicant was found eligible.

The record reflects that you are still eligible only for presumptive Medicaid benefits during the month of June 2017. However, presumptive Medicaid eligibility can be changed to full Medicaid eligibility provided documentary evidence supports such a determination. You were found eligible for full Medicaid benefits in the June 21, 2017 eligibility redetermination. Therefore, because Medicaid eligibility begins on the first day of the month in which you were found eligible, your coverage should have begun on June 1, 2017.

Accordingly, since NYSOH has accepted your income documentation as of June 21, 2017 for a redetermination for full Medicaid eligibility, your case is RETURNED to NYSOH to consider your request to change your Medicaid eligibility from presumptive eligibility to "full" coverage during the month of June 2017.

Your case is RETURNED to NYSOH to consider changing your Medicaid eligibility from presumptive eligibility to "full" coverage Medicaid, beginning June 1, 2017 through June 30, 2017 based on a three-person household, utilizing 223% of the 2017 monthly FPL for a pregnant woman.

Decision

Your case is RETURNED to NYSOH to consider changing your Medicaid eligibility from presumptive eligibility to "full" coverage Medicaid, beginning June

1, 2017 through June 30, 2017 based on a three-person household, utilizing 223% of the 2017 monthly FPL for a pregnant woman.

Effective Date of this Decision: January 16, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for financial assistance.

Your case is RETURNED to NYSOH to consider changing your Medicaid eligibility from presumptive eligibility to "full" coverage Medicaid, beginning June 1, 2017 through June 30, 2017 based on a three-person household, utilizing 223% of the 2017 monthly FPL for a pregnant woman.

NYSOH will notify you promptly of its redetermination.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

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

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

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

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

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

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

- By fax: 1-877-369-0129

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

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

Your case is RETURNED to NYSOH to consider changing your Medicaid eligibility from presumptive eligibility to “full” coverage Medicaid, beginning June 1, 2017 through June 30, 2017 based on a three-person household, utilizing 223% of the 2017 monthly FPL for a pregnant woman.

This is not a final determination of your eligibility for financial assistance.

NYSOH will notify you promptly of its redetermination.

Legal Authority

We are issuing this determination in accordance with 45 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).

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।

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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 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.

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).