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

Notice of Decision

Decision Date: January 09, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023288

[redacted]

[redacted]

On December 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 11, 2017 denial of your request for full Medicaid coverage for the month of September 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: January 09, 2018

NY State of Health Account ID: [redacted]
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[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 September 2017?

Procedural History

According to your NYSOH account, you were found conditionally eligible for Medicaid, effective July 1, 2017, pending submission of proof of income. On July 18, 2017, you submitted a password protected copy of your 2016 income tax return ([redacted]). These documents could not be viewed by the NYSOH and were invalidated by NYSOH on July 19, 2017.

On July 20, 2017, a notice was issued stating that the documentation you submitted did not confirm the information in your application. The notice directed you to provide further proof of your household income before August 4, 2017.

No additional documentation was received by August 4, 2017.

On September 12, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost, effective October 1, 2017, because you did not provide the required income documentation by the deadline.

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On September 15, 2017, you updated your application for health insurance and added your newborn child to that application.

On September 16, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective October 1, 2017. The notice stated that you must pick a health plan before November 29, 2017, to get coverage.

On October 11, 2017, you updated your application for health insurance and you spoke to NYSOH's Account Review Unit and appealed the termination of your Medicaid coverage.

On October 12, 2017, NYSOH issued an eligibility determination notice, based on your October 11, 2017 updated application, stating that you were eligible to receive an advance payment of the premium tax credit of up to $66.00 per month, effective November 1, 2017. The notice stated that you were referred to the Department of Social Service to have your eligibility determined on a different basis.

On December 6, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your request to amend your appeal to not being determined eligible for full Medicaid benefits solely during the month of September 2017 was granted and testimony was received. The record was developed during the hearing and held open to December 21, 2017, to allow you time to submit supporting documents.

On December 20, 2017, you submitted your self-employment records for the month of September 2017 and four out of five of your spouse's September 2017 paystubs. These documents were made part of the record collectively as "Appellant's Exhibit A" and the record closed that day.

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 July 5, 2017. You were found conditionally eligible for Medicaid pending submission of proof of your household income.

2) According to your NYSOH account, on July 18, 2017, you uploaded a copy of your 2016 income tax return. This proof was invalidated by NYSOH because the documents you submitted were password protected and could not be viewed by NYSOH.

3) A notice requesting additional proof of household income before August 4, 2017, was issued on July 20, 2017. No income documentation was received by the deadline.

4) According to your NYSOH account, your child was born on [redacted], and was added to your application on September 15, 2017.

5) You were no longer pregnant at the time of this updated application, and because of your and your spouse's income, you were found eligible to purchase a qualified health plan at full cost.

6) According to your NYSOH account, during an October 11, 2017 telephone call that you made to NYSOH, you requested that your eligibility determination notice be reviewed and to appeal your ineligibility for Medicaid.

7) According to an October 12, 2017 notice, in which NYSOH acknowledges receipt of an appeal request, you are identified as the appellant and the issue on appeal is listed as "Eligibility Determination."

8) You testified that you are seeking full Medicaid benefits solely for the month of September 2017, to help pay for the hospital bills for [redacted] of your child.

9) According to your NYSOH account and your testimony, you expect to file your 2017 taxes with a tax filing status of married filing jointly and will claim one dependent on that tax return.

10) The application that was submitted on September 15, 2017, listed an annual household income of $42,643.00. You testified that this amount was incorrect in that your annual household income was $38,142.00, consisting of your spouse's earnings from his employment and $19,643.00 of your earnings earn from your employment.

11) You testified that you had no income in the month of September 2017.

12) According to the documentation you submitted and your testimony, your spouse received $3,391.76 in gross monthly earnings in September 2017, calculated as follows:

Paystub Date and Income Reported:		
9/1/17 Year to Date (YTD)	$	25,294.50
Less 9/1/17 – Weekly Pay	<	733.50>
To reach YTD Income as of 8/25/17:		$ 24,561.00

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Paystub Date and Income Reported:	
9/29/17 YTD	$ 27,952.76
Less 8/25/17 YTD	< 24,561.00>
Sept. 2017 Gross Income	$ 3,391.76

(*see* Appellant's Exhibit A, pp. 9–12).

13) A letter, dated December 13, 2017, from the owner of the establishment where you worked as [redacted] shows you went on [redacted] as of September 1, 2017, and were not issued any paychecks for the month of September 2017 (*see* Appellant's Exhibit A, p. 2).

14) According to your NYSOH account, you were determined eligible for a qualified health plan at full cost on September 15, 2017.

15) According to your NYSOH account, you had presumptive Medicaid in September 2017.

16) You testified that the Medicaid coverage you had did not cover certain [redacted] charges related to the birth of your child in September 2017, and you want to appeal those charges not being 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 Code of Federal Regulations (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

Generally, 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)), 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 household size of either a pregnant woman or a 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).

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 July 5, 2017 application under review, that was the 2017 FPL, which is $20,420.00 annually, or $3,795.00 per month, 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 September 2017.

According to your NYSOH account, you were found conditionally eligible for Medicaid, effective July 1, 2017, pending submission of proof of income. This form of Medicaid is known as “presumptive Medicaid” and requires proof of income to confirm that you were actually eligible for Medicaid.

The record reflects that you updated your account and applied for Medicaid for yourself and your newborn child on September 15, 2017. On September 16, 2017, NYSOH issued an eligibility determination notice stating that you were

eligible to purchase a qualified health plan at full cost. Your newborn child was included in that application. However, you reapplied for your child later and he was approved for Medicaid Fee-For-Service for the month of September 2017, so his eligibility for and coverage in Medicaid is not at issue.

Although the record contains a September 16, 2017 eligibility determination notice, it is silent as to your request for "full" Medicaid to cover your hospital bills for [redacted] of your newborn child in September 2017. The record does contain evidence of an October 11, 2017 telephone call you made to NYSOH in which you requested that your eligibility determination notice be reviewed and to appeal your ineligibility for Medicaid, along with an October 12, 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."

Here, the lack of an eligibility determination notice on the issue of full Medicaid for you for the month of September 2017 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 October 12, 2017 notice, which acknowledges the appeal on the issue of your eligibility, and the record of the telephone call you made to NYSOH on October 11, 2017, along with your testimony that you were solely seeking help covering the medical expenses you have for the month of September 2017, permits an inference that the NYSOH did deny your request for full Medicaid for yourself in the month of September 2017.

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.

According to your NYSOH account and your testimony, you expect to file your 2017 taxes with a tax filing status of married filing jointly and to claim one dependent on your tax return. In September 2017, you were pregnant with one child. Generally, a pregnant woman and the number of children she is expected to deliver is included in determining household size for Medicaid eligibility. Since you were pregnant in September 2017 with one child, who is now the sole dependent in your household, and you and your spouse expect to file a tax return with the filing status of married filing jointly, for purposes of this analysis you were in a three-person household.

According to your NYSOH account, you had presumptive Medicaid in September 2017, which does not cover certain [redacted] charges. You testified that you are seeking to have your Medicaid coverage changed to "full" Medicaid coverage for the month of September 2017, so that all [redacted] charges related to your child's birth can be covered.

The record reflects that, on July 5, 2017, you submitted your updated application and requested to be considered for Medicaid coverage.

In your case, you were found presumptively eligible for Medicaid on July 6, 2017 and, although you submitted proof of income, that documentation (your 2016 income tax return) could not be verified by NYSOH because it was password protected. By notice, dated July 20, 2017, you were informed that the documentation you submitted did not confirm the information in your application and were directed you to provide further proof of your household income before August 4, 2017. No documentation was submitted by that deadline and, as a result, your eligibility for full Medicaid could not be determined. Instead, you were redetermined eligible for a qualified health plan at full cost, effective October 1, 2017.

You next updated your account on September 15, 2017, and were found eligible for a qualified health plan at full cost, effective October 1, 2017.

On October 11, 2017, you requested an appeal of your eligibility determination insofar as you were not found eligible for “full” Medicaid for the month of September 2017. On December 20, 2017, based on the request of the Hearing Officer, you submitted proof of your household income for the month of September 2017.

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 at any time that month.

To be eligible for Medicaid in September 2017 as a pregnant woman, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the 2017 FPL, which is $3,795.00 per month for a three-person household size. There is no indication in the record that you would not have been ineligible for Medicaid based on non-financial criteria during the month of September 2017. Therefore, the analysis turns to the financial requirements of Medicaid.

The record reflects that, on December 20, 2017, you submitted paystubs for your spouse for the month of September 2017 that show he received gross monthly earnings from his employment in the amount of $3,391.76, as can be deduced from his first and fourth paystubs, dated September 1, 2017 and September 29, 2017. You further testified and provided documentation to show that you had no income in September 2017, and that your spouse’s income was your household’s sole source of support that month. Therefore, your gross household income for the month of September 2017 is $3,391.76.

Generally, the Department of Health will change the presumptive Medicaid eligibility to full Medicaid eligibility provided documentary evidence supports such

a determination. 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. In your case, that date is September 1, 2017.

Since the record now contains a more accurate representation of what your gross household income was for the month of September 2017, your case is RETURNED to NYSOH to reconsider your eligibility for full Medicaid for the month of September 2017, based on a three-person household, 223% of the 2017 FPL for a pregnant woman, and a gross monthly household income of $3,391.76, and to notify you accordingly.

Decision

Your case is RETURNED to NYSOH to reconsider your eligibility for full Medicaid for the month of September 2017, based on a three-person household, 223% of the 2017 FPL for a pregnant woman, and a gross monthly household income of $3,391.76, and to notify you accordingly.

Effective Date of this Decision: January 09, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for financial assistance in the month of September 2017.

Your case is being sent back to NYSOH to redetermine your eligibility for full Medicaid based on the household size and month income information as noted above. NYSOH will notify you of its redetermination.

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

Your case is RETURNED to NYSOH to reconsider your eligibility for full Medicaid for the month of September 2017, based on a three-person household, 223% of the 2017 FPL for a pregnant woman, and a gross monthly household income of $3,391.76, and to notify you accordingly.

This is not a final determination of your eligibility for financial assistance in the month of September 2017.

Your case is being sent back to NYSOH to redetermine your eligibility for full Medicaid based on the household size and month income information as noted above. NYSOH will notify you of its redetermination.

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.

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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 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.

(Urdu)اردو

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)

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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.

(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.

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