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

Notice of Decision

Decision Date: May 22, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027631

[redacted]

Dear [redacted]

On March 27, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 23, 2018 denial of your request for full Medicaid coverage for the month of October 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: May 22, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027631

[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 October 2017?

Procedural History

On September 6, 2017, NYSOH issued an eligibility determination notice, based on your September 5, 2017 application, stating that you were eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective September 1, 2017. The notice directed you to provide proof of your income before September 20, 2017.

On September 21, 2017 and October 10, 2017, you uploaded proof of your income, which were letters from your employer, dated September 11, 2017 and October 3, 2017 respectively (*see* Documents [redacted] and [redacted] NYSOH validated these documents on October 11, 2017

On October 12, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium for a limited time, effective November 1, 2017. The notice stated that you were not eligible for Medicaid because the household income your provided was over the allowable income limit for that program. The notice further directed you to provide proof of your income before January 9, 2018.

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).

Also on October 12, 2017, you updated your NYSOH account and added your newborn child to your account.

On October 16, 2017, NYSOH issued an eligibility determination notice, based on your October 12, 2017 updated application, stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium for a limited time, effective November 1, 2017. The notice stated that you were not eligible for Medicaid because the household income your provided was over the allowable income limit for that program. The notice further directed you to provide proof of your income before January 9, 2018.

On November 4, 2017, NYSOH issued a notice stating that the income information in your application did not match what NY State of Health received from state and federal data sources. The notice directed you to provide proof of household income by November 18, 2017 to confirm your eligibility.

On November 14, 2017, you uploaded proof of your income, which was a letter from your employer, dated November 10, 2017 (*see* Document [redacted] NYSOH validated the document that same day.

On November 15, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective November 1, 2017.

On January 5, 2018, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid as of January 1, 2018, and that your newborn was eligible for Medicaid as of January 1, 2018.

On January 5, 2018, NYSOH issued an eligibility determination notice stating that your newborn was eligible for Medicaid from October 1, 2017 through December 31, 2017. This was because your child's household income of $0.00 was at or below the monthly income limit of $3,018.00.

On January 23 ,2018, you spoke to NYSOH's Account Review Unit and appealed not being determined eligible for full Medicaid benefits during the month of October 2017.

On January 24, 2018, NYSOH issued a notice in which NYSOH acknowledges receipt of an appeal request, and identifies you as the appellant and the issue on appeal as "Eligibility Determination."

On March 27, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to April 11, 2018, to allow you time to submit supporting documentation.

On April 11, 2018, you submitted a copy of a letter of attestation, dated April 11, 2018; an email from your employer, dated April 6, 2018; copies of your paystubs and invoices from [redacted], dated August 11, 2017 through December 4, 2017; and a copy of your 2017 Federal Income Tax Return 1040 form. These documents were made part of the record collectively as "Appellant's [redacted] No further documentation was received 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 September 5, 2017. You were found conditionally eligible for Medicaid pending submission of proof of your income.

2) According to your NYSOH account, on September 21, 2017 and October 10, 2017, you uploaded proof of your income, which was validated by NYSOH on October 11, 2017. The Notes Tab in your NYSOH account shows that your gross annual income was determined to be $20,571.43 based on your submitted proof of income.

3) Your application submitted on October 11, 2017 states that you are married but filing single.

4) According to your testimony and submitted documentation, you filed your 2017 taxes with a tax filing status of head of household and claimed one dependent on that tax return (*see* Appellant's [redacted]).

5) According to an April 12, 2018 report from eMedNY, NYSOH's Medicaid reporting system, you were eligible for and enrolled in presumptive Medicaid in October 2017.

6) According to your NYSOH account and testimony, your newborn child was born on [redacted] and you added her to your application on October 12, 2017.

7) You testified that, although you were told by a NYSOH representative that all your expenses would be covered, the Medicaid coverage you had did not cover certain [redacted] charges related to the birth of your child [redacted], and you want to appeal those charges not being covered.

8) According to your NYSOH account, on January 23, 2018, you requested help paying for [redacted] bills for [redacted] of your child [redacted]. Your request was denied.

9) According to your NYSOH account, you updated your account on November 14, 2017 and again on January 4, 2018, and requested help paying for medical bills incurred in the three previous months for your newborn child.

10) Your newborn child was found eligible for retroactive Medicaid for the months of October 2017 through December 2017.

11) According to a written telephone record, dated January 23, 2018, you requested help paying for medical bills for the month of your newborn's birth.

12) Your 2017 1040 Form further shows that you received $18,144.00 in 2017, consisting of $12,500.00 in employment income and $6,073.00 in self-employment income.

13) Your 2017 invoices, along with your paystubs, dated from September 26, 2017 through December 4, 2017, show that you received $0.00 in self-employment income in October 2017.

14) According to your NYSOH account, you were determined eligible for and enrolled in an Essential Plan, effective November 1, 2017.

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).

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 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 October 11, 2017 application under review, that was the 2017 FPL, which is $16,240.00 for a two-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 October 2017.

The record reflects that you updated your account and applied for Medicaid for yourself and your unborn child on September 5, 2017. On September 6, 2017, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid, effective September 1, 2017. The notice further stated that you must provide proof of your income before September 20, 2017.

Although the record contains a November 15, 2017 eligibility determination notice on the issue of Medicaid eligibility for November 2017, it is silent as to your request for Medicaid to cover your [redacted] bills for [redacted] of your newborn child [redacted]. The record does contain evidence of a January 23, 2018 telephone call you made to NYSOH in which you requested help paying for medical bills for the month of your newborn's birth, along with a January 24, 2018 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 a notice of eligibility determination on the issue of full Medicaid for you for the month of October 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 January 24, 2018 notice, which acknowledges the appeal on the issue of your eligibility, along with the record of the telephone call made to NYSOH on January 23, 2018, permits an inference that the NYSOH did deny your request for full Medicaid for yourself in the month of October 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. Therefore, the issue under review is refined to whether you were properly denied full Medicaid benefits for the month of October 2017.

According to your testimony, and submitted documentation, you filed your 2017 taxes with a tax filing status of head of household and claimed one dependent on that tax return. In October 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 October 2017 with one child, who is now your dependent in your household, your household size for purposes of this analysis and at all times relevant was a two-person household.

According to your NYSOH account, you had presumptive Medicaid in October 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 October 2017, so that the labor and delivery charges related to your child's birth can be covered.

The record reflects that, on January 23, 2018, you submitted your updated application and requested help paying for medical bills for the past three months; specifically, for full Medicaid in October 2017.

In your case, you were found conditionally eligible for Medicaid on September 5, 2017 and, although you submitted proof of income, you were found eligible for the Essential Plan as of October 11, 2017. As a result, you were never found fully eligible for Medicaid.

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.

To be eligible for Medicaid in October 2017, since you were pregnant that month, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the 2017 FPL, which is $36,215.00 per year for a two-person household size. Since you were pregnant in October 2017 and had presumptive Medicaid coverage, you might have been eligible for full Medicaid in that month provided you met the nonfinancial and financial requirements. 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 October 2017. Therefore, the analysis turns to the financial requirements of Medicaid.

The record reflects that, on September 21, 2017 and October 10, 2017, you uploaded proof of your income, which was validated by NYSOH on October 11, 2017. The Notes Tab in your NYSOH account shows that your gross annual income was determined to be $20,571.43 based on your submitted proof of income. However, you submitted documentation shows that your 2017 gross annual household income to be $18,144.00.

According to your NYSOH account, you were still conditionally eligible for Medicaid in October 2017, therefore, your medical expenses for certain [redacted] charges were not covered by Medicaid. However, 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 October 1, 2017.

Since the record now contains a more accurate representation of what your gross annual household income and household size was for the month of October 2017, your case is RETURNED to NYSOH to consider your request to change your Medicaid eligibility from presumptive eligibility to full Medicaid coverage during that month, based on a two-person household, utilizing 223% of

the 2017 FPL for a pregnant woman, and a gross annual household income of $18,144.00, and to notify you accordingly.

Decision

Your case is RETURNED to NYSOH to consider changing your Medicaid eligibility from presumptive eligibility to “full” coverage in Medicaid for you during the month of October 2017, based on a two-person household, utilizing 223% of the 2017 monthly FPL for a pregnant woman, and a gross annual household income of $18,144.00, and to notify you accordingly.

Effective Date of this Decision: May 22, 2018

How this Decision Affects Your Eligibility

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

Your case is being sent back to NYSOH to redetermine your eligibility for “full” Medicaid coverage for October 2017. This redetermination will be based on the parameters 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 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 changing your Medicaid eligibility from presumptive eligibility to “full” coverage in Medicaid for you during the month of October 2017, based on a two-person household, utilizing 223% of the 2017 monthly FPL for a pregnant woman, and a gross annual household income of $18,144.00, and to notify you accordingly.
This is not a final determination of your eligibility for financial assistance for the month of October 2017.
Your case is being sent back to NYSOH to redetermine your eligibility for “full” Medicaid coverage for October 2017. This redetermination will be based on the parameters 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:

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.

□□□ (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)

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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.

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).