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

Notice of Decision

Decision Date: May 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028534

[redacted]

Dear [redacted]

On April 16, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of full Medicaid coverage for the month of December 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).

This page intentionally left blank.

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

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

Decision

Decision Date: May 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028534

[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 December 2017?

Procedural History

On October 11, 2017, NYSOH issued an eligibility determination notice, based on your October 10, 2017 application, stating that you were conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective October 1, 2017. This notice requested that you submit proof of your household income by October 25, 2017.

On November 18, 2017, NYSOH issued an eligibility determination notice, based on your November 17, 2017 application, stating that you were conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective December 1, 2017. This notice stated that further documentation was needed to verify your income however, it did not provide a deadline for such documentation.

On November 22, 2017, you uploaded four of your most recent paystubs for October and November 2017 to your NYSOH account.

On November 23, 2017, NYSOH issued an eligibility determination stating that you are eligible for tax credits up to $140.00 per month, effective January 1, 2018.

NYSOH never made a final determination regarding your conditional eligibility for Medicaid for the month of December 2017.

On February 6, 2018, 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 December 2017.

On April 16, 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 up to May 1, 2018, to allow you time to submit supporting documents.

On April 19, 2018, NYSOH received your supporting documents by upload. The documents were incorporated in the record as Appellant's Exhibit #1 and the record was closed.

Findings of Fact

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

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

2) According to your NYSOH account, you provided income documentation on November 22, 2017, which consisted of the most recent paystubs issued to you by your employer for October and November 2017, totaling $3,566.06.

3) NYSOH records reflect that on November 22, 2017, NYSOH updated your annual income from $31,200.00 to $46,358.78 based on your November 22, 2017 submission of proof of income; however, NYSOH did not make a determination regarding your presumptive eligibility for Medicaid for the month of December 2017.

4) Your NYSOH enrollment details reflect that your conditional or presumptive eligibility, which began on October 1, 2017, ended on December 31, 2017 because you were deemed over income.

5) Your child was born on [redacted]

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

7) You testified that you were seeking “full” Medicaid eligibility during the month of December 2017, so that the bills incurred by you during that time could be paid.

8) You uploaded the following paystubs from your employer as proof of income for the month of December 2017:

    a. December 8, 2017 - $157.50;
    b. December 15, 2017 - $892.50;
    c. December 22, 2017 – $892.50; and
    d. December 29, 2017 - $420.00.

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 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 application, 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 December 2017.

You testified that you were seeking “full” Medicaid eligibility during the month of December 2017, so that unpaid bills incurred by you during that time could be paid. However, the record does not contain a final determination regarding your eligibility for “full” Medicaid for the month of December 2017.

Here, the lack of a notice of eligibility determination on the issue of “full” Medicaid does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. 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.

Your credible testimony that you are appealing to be found eligible for full Medicaid along with NYSOH enrollment details which reflect that you were only conditionally eligible for Medicaid for the month of December 2017, permit an inference that NYSOH did deny your request to be determined fully eligible for Medicaid for the month of December 2017.

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.

According to your NYSOH account and your testimony, based on your October 10, 2017 application, you were found eligible for Medicaid on a conditional basis, pending receipt of additional income documentation, effective October 1, 2017. This presumptive Medicaid eligibility continued until December 31, 2017, when it was terminated after NYSOH determined you were over income.

Your NYSOH account reflects that you had presumptive Medicaid during December 2017, which does not cover labor and delivery charges. 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 unpaid hospital charges related to your child's birth can be covered.

Because you were pregnant, to be eligible for full Medicaid during the month of December 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 $36,216.00 for the year, or $3,018.00 per month for a two-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 December 2017. Therefore, the analysis turns to the financial requirements of Medicaid.

On April 19, 2018, you uploaded paystubs issued to you by your employer, totaling $2,362.50 for the month of December 2017.

Accordingly, 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 December 2017 based on a monthly income of $2,362.50 for a two-person household, utilizing 223% of the 2017 FPL for a pregnant woman.

Decision

Your case is RETURNED to NYSOH to consider your request to change your Medicaid eligibility from presumptive eligibility to "full" coverage Medicaid for the month of December 2017 based on a monthly income of $2,362.50 for a two-person household, utilizing 223% of the 2017 monthly FPL for a pregnant woman and to notify you of its redetermination.

Effective Date of this Decision: May 11, 2018

How this Decision Affects Your Eligibility

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

Your case is sent back to NYSOH to redetermine your eligibility based on the information you submitted during your hearing.

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, for the month of December 2017 based on a monthly income of $2,362.50 for a two-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.

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 1-855-355-5777번으로 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।

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).

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).