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

Notice of Decision

Decision Date: April 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013255

[redacted]

[redacted]

Dear [redacted],

On March 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 9, 2016 eligibility determination.

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).

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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: April 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013255

[redacted]

[redacted]

Issue

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

> Should NY State of Health have determined you fully eligible for Medicaid, effective April 1, 2016?

Procedural History

On March 8, 2016, you updated your application for financial assistance with health insurance through NY State of Health (NYSOH).

On March 9, 2016, NYSOH issued a notice of eligibility determination stating that you were conditionally eligible for Medicaid, effective April 1, 2016. This notice indicated that additional information was required in order to confirm your eligibility and requested that you submit income documentation for your household by March 23, 2016.

On March 9, 2016 income documentation was uploaded to your NYSOH account.

On March 16, 2016, this documentation was reviewed by NYSOH and determined insufficient to resolve the inconsistency in your account.

On March 17, 2016, NYSOH issued a notice stating that the income documentation you submitted was insufficient to resolve the inconsistency in your account and additional proof of income for your household was required.

On May 20, 2016, May 27, 2016, and June 7, 2016, additional income documentation was uploaded to your NYSOH account.

On June 16, 2016, this documentation was reviewed by NYSOH and determined insufficient to resolve the inconsistency in your account.

On June 17, 2016, NYSOH issued a notice stating that the income documentation you submitted was insufficient to resolve the inconsistency in your account and additional proof of income for your household was required.

On July 28, 2016, your authorized representative submitted a letter asking that your eligibility for full Medicaid for April 2016 be determined.

On July 28, 2016, August 30, 2016, and November 11, 2016 additional income documentation was uploaded to your NYSOH account.

On October 31, 2016, NYSOH received a letter from your authorized representative requesting that your eligibility for full Medicaid for April 2016 be determined.

On November 14, 2016, you spoke to NYSOH's Account Review Unit and appealed the failure of NYSOH to redetermine your eligibility for Medicaid for the month of April 2016.

On March 2, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing [redacted] acted as your Authorized Representative and assisted you with your testimony. Your spouse was also present and provided sworn testimony. The record was developed during the hearing and held open until March 16, 2017, to allow you to submit supporting documents.

On March 7, 2017, you uploaded income documentation to your NYSOH account consisting of your 2016 W-2, your spouse's 2016 W-2 and 1099s, and your spouse's earnings for April 2016. 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 support the following findings of fact:

1) Your Authorized Representative testified that you are seeking full Medicaid coverage for yourself for April 2016. This is because the bills associated with the birth and hospital delivery services are not covered under presumptive Medicaid.

2) You testified that you were pregnant from [redacted]

3) Your spouse testified that you have not yet filed your 2016 tax return, but plan to file as married filing jointly and will claim one dependent on that return.

4) You testified that in 2016 you only worked for one employer, [redacted]. You explained that you worked as a [redacted] and were paid per diem based on the days and hours you worked. You testified that the school district issued pay checks every two weeks.

5) You submitted three paystubs that show in April 2016 you were paid $675.00; the first was for pay date April 1, 2016 for a gross of $360.00, the second was for pay date April 15, 2016 for a gross pay amount of $135.00; and the third was for pay date April 29, 2016 for a gross pay amount of $135.00.

6) You submitted your 2016 W-2 which indicates a gross income of $4,578.91.

7) Your spouse testified that in 2016 he worked for three employers, [redacted], [redacted], and [redacted]. Your spouse explained that [redacted], so these were essentially the same entity. Your spouse further explained that he is considered an independent contractor for [redacted] and [redacted]. Your spouse testified that the job with [redacted] is seasonal and that he only did a little work for them in April 2016. Your spouse testified that he is paid $640.00 per week gross by [redacted] and that he is paid every Friday.

8) You submitted a letter from your spouse's employer, [redacted], dated February 22, 2016 indicating that your spouse is salaried and is paid $640.00 per week gross.

9) You submitted your spouse's 2016 W-2 from [redacted] showing gross earnings of $35,987.68.

10) You submitted a receipt from [redacted] indicating that your spouse was paid $150.00 on April 30, 2016.

11) You submitted your spouse's 2016 1099 from [redacted] indicating gross income of $1,215.00.

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).

12) You submitted your spouse's 2016 1099 from [redacted] indicating gross income of $6,630.01.

13) Your spouse testified that he will be claiming business expense deductions on your 2016 joint tax return of approximately $6,700.00.

14) You testified that you reside in [redacted].

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

Medicaid

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Medicaid Managed Care plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments

received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; *see* 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

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 2 months after the month in which the pregnancy ends (N.Y. Soc. Serv. 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.

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 January 15, 2016 application under review, that was the 2015 FPL, which is $28,410.00 for a five-person household (80 Fed. Reg. 3236, 3237).

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 should have determined you fully eligible for Medicaid, effective April 1, 2016.

According to your NYSOH account and your testimony, you expect to file your 2016 taxes with a tax filing status of married filing jointly and to claim one dependent on that tax return.

In April 2016, 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 April 2016 with one child, who is now the dependent in your household, and resided with your spouse, your household size for purposes of this analysis and at all times relevant was a three-person household.

According to your NYSOH account, you had conditional (presumptive) Medicaid in April 2016, which does not cover labor and delivery charges. You testified that you are seeking to have your Medicaid coverage changed to "full" Medicaid coverage for the month of April 2016, so that the labor and delivery charges related to your child's birth can be covered.

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 April 2016.

To be eligible for Medicaid in April 2016, 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 2016 FPL, which was $44,957.00 for a three-person household. Since you were pregnant in April 2016 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 April 2016. Therefore, the analysis turns to the financial requirements of Medicaid.

The record reflects that, on March 8, 2016, you submitted your updated application. You were subsequently found presumptively eligible for Medicaid on March 9, 2016. On March 9, 2016, May 20, 2016, May 27, 2016, June 7, 2016, July 28, 2016, August 30, 2016, and November 11, 2016 income documentation was uploaded to your NYSOH account. However, this documentation was insufficient to resolve the inconsistency in your account.

Since NYSOH was unable to determine whether you were fully eligible for full Medicaid benefits for the month of April 2016, the March 9, 2016 eligibility determination is AFFIRMED.

Following the hearing, you submitted income documentation which shows that your household income for 2016 was $41,711.60.

Since the record now contains a more accurate representation of what your household income was for 2016, your case is RETURNED to NYSOH to consider

your request for changing your Medicaid eligibility from presumptive eligibility to full coverage during April 2016, based on a three-person household, utilizing 223% of the 2016 FPL for a pregnant woman, and an annual household income of $41,711.60.

Decision

The March 9, 2016 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for changing your Medicaid eligibility from presumptive eligibility to full coverage during April 2016, based on a three-person household, utilizing 223% of the 2016 FPL for a pregnant woman, and an annual household income of $41,711.60.

Effective Date of this Decision: April 3, 2017

How this Decision Affects Your Eligibility

This is not a final determination on your eligibility for April 2016.

Your case is being sent back to NYSOH to redetermine your eligibility for full Medicaid benefits for April 2016 based on the income documentation you submitted.

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

The March 9, 2016 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to consider your request for changing your Medicaid eligibility from presumptive eligibility to full coverage during April 2016, based on a three-person household, utilizing 223% of the 2016 FPL for a pregnant woman, and an annual household income of $41,711.60.

This is not a final determination on your eligibility for April 2016.

Your case is being sent back to NYSOH to redetermine your eligibility for full Medicaid benefits for April 2016 based on the income documentation you submitted.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

[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.

(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)

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).