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

Notice of Decision

Decision Date: March 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024721

[redacted]

Dear [redacted],

On February 15, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 22, 2017 eligibility determination notice.

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

Decision

Decision Date: March 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024721

[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 conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective November 1, 2017?

Procedural History

On November 21, 2017, you applied for health insurance and financial assistance through NYSOH, and indicated that you were pregnant.

On November 22, 2017, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective November 1, 2017. That notice also stated that additional information was needed to verify your income.

Also on November 22, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not eligible for the Essential Plan.

On November 23, 2017, NYSOH issued a notice indicating the documents you submitted were reviewed but did not confirm the information in your application. The notice directed you to submit proof of income by December 21, 2017.

On November 27, 2017, you submitted several applications for health insurance.

On November 28, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective January 1, 2018.

On November 29, 2017, you submitted an updated application for financial assistance with health insurance.

On November 30, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective January 1, 2018. That notice also stated that additional information was needed to verify your income.

On December 1, 2017, NYSOH issued a notice stating that you were eligible for the Essential Plan for a limited time, effective December 1, 2017. This was because you had been granted Aid to Continue pending the outcome of your appeal.

Also on December 1, 2017, NYSOH issued a plan enrollment notice stating that you were enrolled in the Essential Plan, effective January 1, 2018.

On February 15, 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 March 1, 2018, to allow you time to submit supporting documents.

On February 17, 2018, NYSOH received your supporting documents by upload. The documents were made part of 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) You testified that you expect to file your tax return for 2018 with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking health insurance for yourself, and do not want Medicaid coverage.

3) The application that was submitted on November 21, 2017, listed annual household income of $28,000.00, consisting of income you earn from your employment. You testified that this amount was correct for 2017.

4) You were determined conditionally eligible for Medicaid as of November 1, 2017, based on your reported income of $28,000.00. This eligibility is

known as presumptive Medicaid pending documentary evidence of income to confirm your eligibility.

5) You submitted a 2017 W-2 forms for [redacted], showing gross annual earnings of $19,523.11.

6) You submitted a 2017 1099-MISC form from [redacted] showing gross annual earnings of $17,440.00.

7) You testified that you expect to earn around $40,000.00 in 2018.

8) The application that was submitted on November 21, 2017, stated that you were pregnant with one child, with a [redacted] due date.

9) You testified that you are currently pregnant.

10) Your application states that you will not be taking any deductions on your 2018 tax return. You testified that you expect to deduct business expenses.

11) Your application states that you live in [redacted], NY.

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

Applicable Law and Regulations

Medicaid 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 is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); New York State Department of Health 13 OHIP/ADM-03).

Once eligible, a pregnant woman will remain eligible until the end of the month in which the sixtieth day following the end of the pregnancy occurs, regardless of any change in household income, even if such change would render her ineligible for financial assistance (NY Social Services Law § 366(4)(b)(1)).

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person 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 application that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Federal Register 8831).

Verification Process

For all individuals, whose income is needed to calculate the household's eligibility, NYSOH must request data from state and federal data sources 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).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective November 1, 2017

The application that was submitted on November 21, 2017, stated that you were pregnant and listed an annual household income of $28,000.00. The eligibility determination relied upon that information. According to your account, NYSOH was unable to verify the income information in your application.

On November 22, 2017, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective November 1, 2017. That notice also stated that additional information was needed to verify your income to determine your eligibility for full Medicaid.

Pursuant to the above cited regulations, for all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow it to verify the household's income. 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.

According to your NYSOH account, you expect to file your 2017 income tax return as single and will claim no dependents on that tax return. When calculating family size for Medicaid purposes, however, the household size of either a pregnant woman or a person 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. On the date of your November 21, 2017 application, you were pregnant with one child. Consequently, NYSOH determined your eligibility for Medicaid using a two-person household.

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $28,000.00 is 172.41% of the 2017 FPL, NYSOH properly determined that the income listed in your application was within the limit for Medicaid for a pregnant woman.

However, due to the outstanding income document request and NYSOH's inability to verify your household income, your account confirms that you were determined conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services only on an expected annual income basis, effective November 1, 2017, using the information provided in your application. Since your income could not be verified, your eligibility for full Medicaid could not be determined,

Since the November 22, 2017 eligibility determination notice properly stated that, based on the information you provided, you were conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services only, effective November 1, 2017, it is AFFIRMED.

However, after the hearing, you submitted additional income documentation in support of your testimony. You submitted a 2017 W-2 form for [redacted], showing gross annual earnings of $19,523.11, and a 2017 1099-MISC form from [redacted] showing gross annual earnings of $17,440.00, which equals $36,963.11. Based on these two documents, you misreported your income in 2017 as $28,000.00 on your application, and falsely testified at hearing that this amount was correct for 2017, unless you can show that you took a deduction for your business expenses of $8,963.11 in 2017, and expect to take a similar deduction in 2018. You further testified that you expect your gross income to be $40,000.00 in 2018.

Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as a pregnant woman residing in Queens County, in a two-person household with a household income of $40,000.00.

You can report any deductions you expect to take in 2018 to NYSOH.

Decision

The November 22, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as a pregnant woman residing in Queens County, in a two-person household with a household income of $40,000.00.

Effective Date of this Decision: March 23, 2018

How this Decision Affects Your Eligibility

You were properly determined eligible for Medicaid coverage for all outpatient prenatal Medicaid services only, effective November 1, 2017.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility based on the completed record as noted above.

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
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The November 22, 2017 eligibility determination notice is AFFIRMED.

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).

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as a pregnant woman residing in Queens County, in a two-person household with a household income of $40,000.00.

You were properly determined eligible for Medicaid coverage for all outpatient prenatal Medicaid services only, effective November 1, 2017.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility based on the completed record as noted above.

Legal Authority

We are sending you this notice 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.

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 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.

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).