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

Notice of Decision

Decision Date: August 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018304

[redacted]

Dear [redacted],

On July 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 1, 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
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Decision

Decision Date: August 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018304

[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 eligible for Medicaid, effective March 1, 2017?

Procedural History

On March 5, 2017, NYSOH issued a disenrollment notice stating that your Essential Plan coverage ended effective March 31, 2017 because you were no longer eligible to remain enrolled in the Essential Plan.

On March 31, 2017, you submitted an updated application for financial assistance. This application reflected that you were pregnant with one child, with an expected due date of [redacted].

On April 1, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective March 1, 2017. The notice further stated that you were no longer eligible for the Essential Plan as of February 28, 2017.

On April 6, 2017, you submitted an updated application for financial assistance. This updated application reflected that you were no longer pregnant.

On April 7, 2017, NYSOH issued an eligibility redetermination notice stating that you remained eligible for Medicaid, effective April 1, 2017.

On April 24, 2017, you spoke to NYSOH's Account Review Unit and appealed that you had been found eligible for Medicaid, rather than for the Essential Plan.

On July 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim your two children as dependents on that tax return.

2) You are seeking insurance for yourself, since your two children were already enrolled in Child Health Plus.

3) The application that was submitted on March 31, 2017 listed annual household income of $37,000.00, consisting of solely of income you received from your employer, [redacted]. You testified that this amount was correct. This application also reflected that you were pregnant with one child, with an anticipated delivery date of [redacted]

4) You testified that while the income information in the application was correct, you were not pregnant at that time. You further testified that when you spoke with the NYSOH representative on March 31, 2017 to update your account, you mentioned that your [redacted], but never stated that you were pregnant.

5) Based on the information contained in the March 31, 2017 application, you were found eligible for Medicaid, effective March 1, 2017.

6) You testified, and your NYSOH account reflects, that you further updated your application on April 6, 2017 to have it reflect that you were not pregnant. However, NYSOH issued a notice stating that you remained eligible for Medicaid, effective April 1, 2017.

7) You testified that you were seeking to be redetermined eligible for the Essential Plan since a NYSOH representative erroneously reflecting that you were pregnant within the March 31, 2017 application.

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

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)), 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 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 Federal Register 3236, 3237).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR

§ 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is $20,160.00 for a three-person household (81 Fed. Reg. 4036).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

Legal Analysis

The issue is whether NYSOH properly determined that you were eligible for Medicaid, effective March 1, 2017.

The application that was submitted on March 31, 2017 listed an annual household income of $37,000.00, and indicated that you were pregnant with one child, with an expected delivery date of [redacted]. The eligibility determination relied upon that information.

You testified, and your application reflects, that you expect to file your 2017 income taxes as head of household and will claim both of your children as dependents on that tax return.

Generally, a pregnant woman and the number of children she is expected to deliver is included in determining household size for Medicaid eligibility.

Accordingly, NYSOH determined your eligibility based on a four-person household.

You credibly testified, however, that while the income information in the application was correct, you were not pregnant at that time. You further credibly testified that when you spoke with the NYSOH representative on March 31, 2017 to update your account, you mentioned that your [redacted], but never stated that you were actually pregnant.

Since the April 1, 2017 eligibility determination notice is no longer supported by the record, it is RESCINDED.

The April 7, 2017 eligibility determination notice is also RESCINDED since it was issued, in part, based on the findings contained in April 1, 2017 eligibility determination notice.

Furthermore, your case is RETURNED to (1) redetermine your eligibility as of March 31, 2017, based on a three-person household in Niagara County, with an annual household income of $37,000.00, (2) facilitate your selection of a health plan as of March 31, 2017, and (3) reinstate your Essential Plan coverage through March 31, 2017.

Decision

The April 1, 2017 eligibility determination notice is RESCINDED.

The April 7, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to (1) redetermine your eligibility as of March 31, 2017, based on a three-person household in [redacted], with an annual household income of $37,000.00, (2) facilitate your selection of a health plan as of March 31, 2017, and (3) reinstate your Essential Plan coverage through March 31, 2017.

Effective Date of this Decision: August 23, 2017

How this Decision Affects Your Eligibility

Your Essential Plan coverage is reinstated for the month of March 2017.

You will receive a new eligibility determination notice reflecting your eligibility for financial assistance as of March 31, 2017.

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 April 1, 2017 eligibility determination notice is RESCINDED.

The April 7, 2017 eligibility determination notice is RESCINDED.

Your case is being sent back to NYSOH to (1) redetermine your eligibility as of March 31, 2017, based on a three-person household in [redacted], with an annual household income of $37,000.00, (2) facilitate your selection of a health plan as of March 31, 2017, and (3) reinstate your Essential Plan coverage through March 31, 2017.

You will receive a new eligibility determination notice reflecting your eligibility for financial assistance as of March 31, 2017.

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.

□□□□□ (Bengali)

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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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).