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

Notice of Decision

Decision Date: November 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018957

[redacted]

[redacted]

On October 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 18, 2016 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 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: November 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018957

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health properly determine that you were no longer eligible for Medicaid through NYSOH as of October 31, 2016?

Procedural History

On September 20, 2016, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance. This application indicated that you were pregnant with one child and that child was due on [redacted].

On September 21, 2016, NYSOH issued an eligibility determination stating that you were conditionally eligible for Medicaid, effective September 1, 2016. The notice directed you to submit household income documentation to confirm your eligibility by October 5, 2016.

On September 29, 2016, you faxed a four-page document to NYSOH; which was uploaded to your NYSOH account on October 6, 2016.

On October 17, 2016, NYSOH validated your income documentation and an updated application was submitted on your behalf. This application did not indicate that you were pregnant.

On October 18, 2016, NYSOH issued an eligibility determination stating that you were eligible for the Essential Plan, effective November 1, 2016. This notice also stated that you were no longer eligible for Medicaid through NYSOH as of October 31, 2016. This notice stated that this was because your household income is less than the allowable income limit for the Essential Plan, and you are in the first five years of your qualified immigration status or are living in the United States under the color of law (PRUCOL).

On December 5, 2016, NYSOH received an updated application for financial assistance. You also faxed a one-page document to NYSOH on this date.

On December 6, 2016, NYSOH issued an eligibility determination stating that you were conditionally eligible for Medicaid, effective January 1, 2017. The notice directed you to submit income document to confirm this eligibility by December 20, 2016.

On December 10, 2016, NYSOH uploaded the one-page document you faxed on December 5, 2016 to your NYSOH account.

On December 28, 2016, NYSOH invalidated the documentation you submitted on December 5, 2016.

On December 29, 2016, NYSOH issued a notice stating that the documentation you provided did not confirm the information in your application. This notice further directed you to send additional documentation by January 19, 2017.

On January 23, 2017, you faxed a two-page document to NYSOH; which was uploaded to your NYSOH account on February 15, 2017.

On February 17, 2017, NYSOH received your updated application for financial assistance.

On February 18, 2017, NYSOH issued an eligibility determination stating that you remained conditionally eligible for Medicaid, effective February 1, 2017. This notice further directed you to submit income documentation to confirm your eligibility by February 18, 2017.

On May 15, 2017, you spoke to NYSOH’s Account Review Unit and appealed your coverage for the month of February 2017 because you have unpaid medical bills from the month of delivery.

On August 23, 2017, you had a telephone hearing scheduled with a Hearing Officer from NYSOH’s Appeals Unit. The Hearing Officer was unable to reach you on this date; therefore, your appeal was dismissed as a failure to appear.

On September 15, 2017, you contacted NYSOH's Account Review Unit and requested that the dismissal, issued on August 25, 2017, be vacated for good cause; which was granted.

On October 18, 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) The application that was submitted on September 20, 2016 indicated that you were pregnant with one child with a due date of [redacted]

2) The record indicates that you were found conditionally eligible for Medicaid, effective September 1, 2016.

3) The record indicates that you faxed a four-page document to NYSOH on September 29, 2016; which was uploaded to your account on October 6, 2016.

4) The record indicates that this income documentation was validated by NYSOH on October 17, 2016 and an updated application was submitted on your behalf.

5) The application that was submitted on October 17, 2016 did not indicate you were pregnant.

6) You testified that you were pregnant, and gave birth to a newborn child on [redacted] which means that you were also pregnant in [redacted] 2016.

7) The applications that were submitted during all times in question indicate that you are an immigrant non-citizen.

8) You testified, and the record indicates, that you have a permanent resident card.

9) You testified that you obtained your permanent resident status on [redacted], 2014.

10) You testified that you are appealing your coverage that you were eligible for in the month of February 2017 because you have unpaid medical bills associated with your newborn child's birth.

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

Applicable Law and Regulations

Medicaid-Pregnant Women

Medicaid can be provided through NYSOH 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)).

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).

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)).

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).

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.

Qualified Immigrants

In NY State, qualified immigrants who were formerly eligible for Medicaid through the state, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of January 1, 2016 (New York's Basic Health Plan Blueprint, p. 19, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html). This category of qualified immigrants includes individuals lawfully admitted for permanent residence in the United States who are still in their first five years of permanent residency. (18 NYCRR § 349.3, 8 USC § 1613).

Legal Analysis

The issue is whether NYSOH properly determined that you were ineligible for Medicaid as of October 31, 2016.

You submitted an updated application for financial assistance with health insurance on September 20, 2016. This application indicated that you were pregnant with one child and that the child was due on [redacted].

Subsequently, on September 21, 2016, NYSOH issued an eligibility determination stating that you were conditionally eligible for Medicaid, effective September 1, 2016. This notice also directed you to submit income documentation to confirm your eligibility by October 5, 2016.

The record indicates that you faxed income documentation to NYSOH on September 29, 2016 and that this income was uploaded to your account on October 6, 2016. On October 17, 2016, NYSOH validated the income documentation and submitted an updated application on your behalf. This application did not indicate that you were pregnant.

As a result, on October 18, 2016, NYSOH issued an eligibility determination, based on the October 17, 2016 application, stating that you were eligible for the Essential Plan, effective November 1, 2016. This notice also indicated that you were no longer eligible for Medicaid through NYSOH as of October 31, 2016.

You testified, and the record reflects, that at the time of your October 17, 2016 application, you were a permanent resident, and that you have had permanent resident status since [redacted], 2014.

As of January 1, 2016, legal permanent residents who were receiving Medicaid through NY State, but were not eligible for Medicaid under federal law due to being in the first five years of their permanent residency, must receive coverage through the Essential Plan. However, immigration status is not an eligibility requirement for Medicaid for a pregnant woman throughout her pregnancy.

When the NYSOH representative updated your application for financial assistance with health insurance on October 17, 2016, the NYSOH representative failed to indicate that you were pregnant with one child.

You credibly testified that at the time of your October 17, 2016 application, you were pregnant, and immigration status is not an eligibility requirement for Medicaid for a pregnant woman throughout her pregnancy. Therefore, but for the error made by NYSOH on October 17, 2016, you would have met the non-financial and financial requirements for Medicaid and you should have been found fully eligible for Medicaid as of September 1, 2016.

As a result, the October 18, 2016 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to effectuate your eligibility for fee-for-service Medicaid as of September 1, 2016. NYSOH must also assist you in enrolling into a Medicaid Managed Care plan as of October 17, 2016, with a December 1, 2016 enrollment start date, if you so choose.

Decision

The October 18, 2016 eligibility determination is RESCINDED.

This case is RETURNED to NYSOH to enroll you into fee-for-service Medicaid as of September 1, 2016, and to assist you in enrolling into a Medicaid Managed Care plan, as of October 17, 2016, with a December 1, 2016 enrollment start date, if you so choose.

This Decision has no effect on your current eligibility.

The Notice of Dismissal issued August 25, 2017 is superseded by this Decision

Effective Date of this Decision: November 8, 2017

How this Decision Affects Your Eligibility

This decision does not change your current eligibility.

You should have been found fully eligible for fee-for-service Medicaid, effective September 1, 2016.

Your case is being sent back to NYSOH to enroll you into fee-for-service Medicaid as of September 1, 2016.

Your case is also being sent back to NYSOH to assist you in enrolling into a Medicaid Managed Care plan as of October 17, 2016, for a December 1, 2016 start date, if you so choose.

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 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).

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 October 18, 2016 eligibility determination is RESCINDED.

This case is RETURNED to NYSOH to enroll you into fee-for-service Medicaid as of September 1, 2016, and to assist you in enrolling into a Medicaid Managed Care plan, as of October 17, 2016, with a December 1, 2016 enrollment start date, if you so choose.

This Decision has no effect on your current eligibility.

The Notice of Dismissal issued August 25, 2017 is superseded by this Decision

You should have been found fully eligible for fee-for-service Medicaid, effective September 1, 2016.

Your case is being sent back to NYSOH to enroll you into fee-for-service Medicaid as of September 1, 2016.

Your case is also being sent back to NYSOH to assist you in enrolling into a Medicaid Managed Care plan as of October 17, 2016, for a December 1, 2016 start date, if you so choose.

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 1-855-355-5777 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)

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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)

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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.

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