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

Notice of Decision

Decision Date: December 07, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022764

[redacted]

[redacted]

On November 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 1, 2017 eligibility determination and October 18, 2017 disenrollment notices.

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: December 07, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022764

[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 eligible for Medicaid effective September 1, 2017?
>
> Did NY State of Health properly determine that you were no longer eligible for Medicaid effective November 30, 2017?

Procedural History

On August 24, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating you were eligible for APTC up to $534.00 per month, effective October 1, 2017.

On September 21, 2017, NYSOH issued an enrollment notice confirming your enrollment in a bronze level qualified health plan, effective October 1, 2017.

On September 23, 2017, NYSOH received your updated application, that day a preliminary eligibility determination was prepared stating you were eligible for Medicaid, effective September 1, 2017.

On September 24, 2017, NYSOH issued a disenrollment notice terminating your enrollment in your bronze level qualified health plan, effective October 1, 2017. The notice stated this was because you were no longer eligible to enroll in that health plan.

On September 25, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were determined eligible for Medicaid, and no longer eligible for APTC, effective October 1, 2017.

On September 29, 2017, NYSOH issued a renewal notice stating it was time to renew your coverage for 2017. The notice stated that you were now eligible for APTC up to $582.34 per month, effective December 1, 2017.

On October 1, 2017, NYSOH issued a notice of eligibility determination based on your September 23, 2017 application stating you were eligible for Medicaid effective September 1, 2017. The notice stated this was because your household income of $53,000.00 was at or below the allowable income limit for you for that program.

On October 12, 2017, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective November 1, 2017.

On October 18, 2017, NYSOH issued a disenrollment notice stating you were no longer eligible to enroll in your Medicaid Managed Care plan and your coverage would end on November 30, 2017.

On November 28, 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 expect to file your 2017 federal income tax return as married filing jointly. You will claim one dependent on that tax return.

2) According to the September 23, 2017 application, you attested to an expected annual household income of $53,000.00 for 2017. You testified that this income was an accurate representation of your household income.

3) According to your September 23, 2017 application you were pregnant and expecting one child.

4) You were determined eligible for Medicaid effective September 1, 2017, and enrolled in a Medicaid Managed Care plan for a start date of November 1, 2017.

5) According to your September 28, 2017 application you indicated you were no longer pregnant.

6) You testified you [redacted] in late September 2017 and that you only attested in your application on September 23, 2017 that you were expecting a child on advice from a NYSOH representative in order to qualify for a special enrollment period to enroll back into a qualified health plan.

7) You testified that as soon as you realized that you were now determined eligible for Medicaid, you contacted NYSOH and filed an appeal.

8) You testified you are not seeking a backdate in coverage for your enrollment in a health plan.

9) You testified you are only seeking to be determined no longer eligible for Medicaid.

10) The record shows you were disenrolled from your Medicaid Managed Care plan effective November 30, 2017.

11) 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

Medicaid-Pregnant Women

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

On the date of your application, that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 8831).

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).

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)).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for Medicaid effective September 1, 2017.

At the time of your application on September 23, 2017 you indicated you were in a four-person household. 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. Although you are filing your 2017 tax return as married filing jointly and will claim one dependent, you indicated you were expecting a child at that time.

On your September 23, 2017 application, you attested to an expected household income of $53,000.00.

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 $24,600.00 for a four-person household. Since $53,000.00 is 215.45% of the 2017 FPL, NYSOH properly found you to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Therefore, the October 1, 2017 eligibility determination notice stating you were eligible for Medicaid, effective September 1, 2017 was proper and is AFFIRMED.

The second issue is whether NYSOH properly determined that you were no longer eligible for Medicaid, effective November 30, 2017.

On September 28, 2017, you submitted an application indicating that you were [redacted].

On September 29, 2017, NYSOH issued a notice stating that you were now eligible for APTC of up to $582.34 per month, effective December 1, 2017.

On October 18, 2017, NYSOH issued a disenrollment notice stating you were no longer eligible to enroll in your Medicaid Managed Care plan and your coverage would end on November 30, 2017.

Once eligible, a pregnant woman will remain eligible for Medicaid 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.

Since you indicated that you were no longer pregnant in your September 30, 2017 application, your eligibility for Medicaid would continue for only another sixty days. The end of the month in which the sixtieth day fell from your September 28, 2017 would be November 30, 2017.

Therefore, since the October 18, 2017 disenrollment notice ended your coverage in a Medicaid Managed Care plan as of November 30, 2017, it is proper and is AFFIRMED.

Decision

The October 1, 2017 eligibility determination notice is AFFIRMED.

The October 18, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: December 07, 2017

How this Decision Affects Your Eligibility

You were properly determined eligible for Medicaid September 1, 2017.

Your eligibility for Medicaid and your Medicaid Managed Care plan ended November 30, 2017.

This decision has no effect on any determinations made after October 18, 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

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).

The October 1, 2017, eligibility determination notice is AFFIRMED.

The October 18, 2017, disenrollment notice is AFFIRMED.

You were properly determined eligible for Medicaid September 1, 2017.

Your eligibility for Medicaid and your Medicaid Managed Care plan ended November 30, 2017.

This decision has no effect on any determinations made after October 18, 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.

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.

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