



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

## Notice of Decision

Decision Date: February 21, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024886

[REDACTED]

[REDACTED]

On January 17, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 28, 2017 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.

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DEPARTMENT OF HEALTH  
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## Decision

Decision Date: February 21, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024886

[REDACTED]

## Issues

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

Did NY State of Health (NYSOH) properly determine that you were not eligible for Medicaid as of November 27, 2017?

Did NYSOH properly determine that your child was eligible to enroll in Child Health Plus (CHP) at full cost, effective January 1, 2018?

## Procedural History

On September 9, 2016, NYSOH issued a notice of eligibility determination stating that you, [REDACTED] were eligible for Medicaid, effective September 1, 2016, and you were subsequently enrolled in a Medicaid Managed Care plan.

On November 29, 2016, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid, but that your Medicaid coverage would continue until August 31, 2017. This was because certain individuals who qualified for Medicaid would receive coverage for 12 continuous months from the date they were last determined eligible. The notice also stated that your child was eligible for Medicaid, effective November 1, 2016.

On July 2, 2017, NYSOH issued a renewal notice stating that it was time to renew your [REDACTED] application for health insurance. The notice stated that, based on the information available from state and federal data sources, NYSOH could not determine whether you qualified for financial assistance with health insurance, and that you needed to update your application between July 16,

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2017 and August 15, 2017 so that your eligibility could be determined. The notice also stated that no action was necessary on the part of your child, and that her coverage would end as of November 30, 2017, and you would receive a notice regarding her renewal in October 2017.

On July 17, 2017, you updated your NYSOH application. In that application, you indicated that you were pregnant and expecting one child, due on [REDACTED].

On July 18, 2017, NYSOH issued a notice of eligibility determination stating that you remained Medicaid eligible, effective September 1, 2017.

Also on July 18, 2017, NYSOH issued a notice of enrollment confirmation confirming enrollment in a Medicaid Managed Care (MMC) plan for [REDACTED], beginning October 1, 2016, and for your child, beginning November 1, 2016.

On September 21, 2017, NYSOH issued a renewal notice stating that it was time to renew your child's application for health insurance. The notice stated that, based on the information available from state and federal data sources, NYSOH could not determine whether your child qualified for financial assistance with health insurance, and that you needed to update your application between October 16, 2017 and November 15, 2017 so that her eligibility could be determined. The notice further stated that no action was needed regarding coverage for you and your spouse, because you would get a notice about renewing coverage in May 2018, and that your coverage would end on August 31, 2018.

On October 3, 2017, you updated your NYSOH account.

On October 4, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective November 1, 2017. The notice further stated that you could receive services covered by Medicaid by using your Medicaid card, and that the type of coverage for which you were eligible did not require or allow you to select an MMC plan. The notice stated that your child remained eligible for Medicaid, effective November 1, 2016. Finally, the notice directed you to provide documentation of your household income by October 18, 2017 to confirm your eligibility.

Also on October 4, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in your MMC plan was ending, effective October 31, 2017, because the type of coverage you were eligible for did not require/allow you to enroll in a plan.

On October 6, 2017, you uploaded documentation to your NYSOH account and updated your NYSOH application.

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On October 7, 2017, NYSOH issued a notice of eligibility determination stating that you remained conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective November 1, 2017. The notice directed you to submit documentation of your household income by November 2, 2017. The notice also stated that your child remained eligible for Medicaid, effective November 1, 2016.

Also on October 7, 2017, NYSOH issued a notice stating that the income documentation you provided was not sufficient to resolve the inconsistency in your account, and that you needed to provide documentation of your household income by November 2, 2017.

On November 16, 2017, NYSOH redetermined your household's eligibility.

On November 17, 2017, NYSOH issued a notice of eligibility determination stating that you remained conditionally eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective December 1, 2017.

That same day, NYSOH issued a discontinuance notice stating that your child was no longer eligible to enroll in coverage through NYSOH, effective December 1, 2017, because you did not respond to the renewal notice and did not complete her renewal within the required timeframe.

Also on November 18, 2017, NYSOH issued a disenrollment notice stating that your child was disenrolled from her MMC plan, effective November 30, 2017, because she was no longer eligible to enroll in coverage through NYSOH.

On November 27, 2017, you updated your NYSOH application and uploaded documentation to your NYSOH account. That same day, NYSOH prepared a preliminary eligibility determination stating that you were eligible to purchase a qualified health plan (QHP), effective January 1, 2018, and that your child was eligible to enroll in a full cost CHP plan or child only QHP, effective January 1, 2018.

Also on November 27, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal, insofar as you and your child were not eligible for financial assistance with the cost of health insurance. You also requested Aid to Continue, pending the outcome of your appeal.

On November 28, 2017, NYSOH issued a notice of eligibility determination stating that you were newly eligible to enroll in a QHP at full cost, and your child was newly eligible to enroll in full cost CHP or a full cost child-only QHP, effective January 1, 2018. The notice also stated that you and your child were not eligible for Medicaid, the Essential Plan, tax credits, or to receive assistance in paying for

CHP because your household income was over the allowable income limits for those programs.

On December 8, 2017, NYSOH issued a notice of eligibility stating that you were eligible for Medicaid coverage for all outpatient prenatal Medicaid services for a limited time, effective January 1, 2018, and your child was eligible for Medicaid for a limited time, effective December 1, 2017. This was because your request for Aid to Continue was granted, pending the outcome of your appeal.

Also on December 8, 2017, NYSOH issued a notice of enrollment confirmation confirming your child's enrollment in an MMC plan, beginning December 1, 2017. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On January 17, 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 through February 9, 2018 to allow you time to submit supporting documentation.

On January 23, 2018, you uploaded documentation to your NYSOH account. The record is now closed.

## **Findings of Fact**

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

- 1) You testified that you are appealing on behalf of yourself and your child, as your spouse currently has Medicaid through the end of June 2018.
- 2) You testified that you were aware that you are over the income limit for Medicaid, but that you were hoping you and your child might be eligible for some kind of subsidy toward the cost of your health insurance.
- 3) On July 2, 2017, NYSOH sent you a renewal notice, and on July 17, 2017, you updated your NYSOH application for financial assistance.
- 4) Your July 17, 2017 application indicated that you were pregnant and expecting one child, due on [REDACTED]. You testified that this is still correct.
- 5) Your NYSOH account reflects that you were found fully eligible for Medicaid in an eligibility determination dated July 18, 2017, effective September 1, 2017.

- 6) Your NYSOH account reflects that NYSOH issued a renewal notice on September 21, 2017, stating that it was time to renew your child's application for health insurance coverage, and on October 3, 2017, you updated your NYSOH application.
- 7) Your NYSOH account reflects that NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid for the coverage of outpatient prenatal care only, effective November 1, 2017, and that your child remained eligible for Medicaid, effective November 1, 2016. The notice also asked you to provide income documentation, which you uploaded on October 6, 2017.
- 8) On November 27, 2017, you updated your NYSOH application again after your child's coverage was discontinued for an alleged failure to renew.
- 9) Also on November 27, 2017, you uploaded a copy of you and your spouse's 2016 federal income tax return (IRS Form 1040) showing adjusted gross income of \$109,234.00 [REDACTED]
- 10) NYSOH verified this income documentation on November 27, 2017 and redetermined you and your child's eligibility.
- 11) On November 28, 2017, NYSOH issued a notice stating that neither you nor your child were eligible for financial assistance, based on your household income, and this notice is under appeal.
- 12) You testified that you expect to file your 2018 tax return with a status of married, filing jointly.
- 13) You testified that you expect to claim one dependent on your 2017 income tax return, and anticipate claiming two on your 2018 tax return, as you are currently pregnant and due in February 2018.
- 14) You testified that you expect your adjusted gross income for 2017 to be different than what it was for 2016.
- 15) You testified that you and your spouse share ownership of one company, [REDACTED], and that you and your spouse have a [REDACTED] share in a second company, [REDACTED].
- 16) You testified that the majority of your income in 2017 was from [REDACTED] [REDACTED] did not start earning any income at all until August 2017.

- 17) You testified that you are not likely to see much profit from "[REDACTED]" in 2018 either, because of investments that were made.
- 18) You testified that you and your spouse are not on the payroll of "[REDACTED]" and any income you receive from that company is considered a draw.
- 19) You testified that you expect your 2018 gross household income to be similar to 2017.
- 20) You testified that you and your spouse both contribute to separate IRA's on a quarterly basis, and that you each contributed approximately \$12,000.00 in 2017. You testified that you anticipate contributing as much or more in 2018.
- 21) You testified that you file quarterly self-employment taxes for "[REDACTED]".
- 22) You testified that you provided your 2017 income documentation to a CPA, who has determined that your expected household adjusted gross income for 2017 will be \$96,323.00.
- 23) You testified that you live in Monroe County.
- 24) After the hearing, you uploaded documentation to your NYSOH account consisting of the following:
  - a. A one-page cover sheet;
  - b. A letter dated January 19, 2018 from "[REDACTED]" stating that you and your spouse would have adjusted gross income for 2017 of approximately \$96,323.00, after deductions for net loss from "[REDACTED]" \$416.00; self-employment tax of \$9,223.00; and IRA contributions of \$25,000.00;
  - c. A 10-page summary of 2017 income and expenses for "[REDACTED]";
  - d. A three-page breakdown of income and expenses for "[REDACTED]" for the month of October 2017;
  - e. A two-page breakdown of income and expenses for "[REDACTED]" for the month of November 2017;
  - f. A two-page breakdown of income and expenses for "[REDACTED]" the month of December 2017;[REDACTED]).

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



## **Applicable Law and Regulations**

### Medicaid for Adults between the Ages of 19 and 65

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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

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).

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 \$24,600.00 for a four-person household (82 Fed. Reg. 8831).

Generally, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as “continuous coverage” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, citizenship status, lack of state residence, or failing to provide a valid Social Security number (NY Social Services Law § 366(4)(c)).

### 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

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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.

### FPL for Pregnant Women

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); NY Department of Health Administrative Directive 13ADM-03).

### Child Health Plus

CHP is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (see New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (NY PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be “eligible for medical assistance”; that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child’s family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from \$9.00 per month to \$60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is \$9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than \$27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

The CHP premium is \$15.00 per month for a child whose family household income is between 223% and 250% of the FPL, but no more than \$54.00 per month per family (NY PHL § 2510(9)(d)(iii)).

The CHP premium is \$30.00 per month for a child whose family household income is between 251% and 300% of the FPL, but no more than \$90.00 per month per family (NY PHL § 2510(9)(d)(iv)).

The CHP premium is \$45.00 per month for a child whose family household income is between 301% and 350% of the FPL, but no more than \$135.00 per month per family (NY PHL § 2510(9)(d)(v)).

The CHP premium is \$60.00 per month for a child whose family household income is between 351% and 400% of the FPL, but no more than \$180.00 per child (NY PHL § 2510(9)(d)(vi)).

In an analysis of CHP 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 was \$24,600.00 for a four-person household (82 Fed. Reg. 8831).

### Household Size

For purposes of Medicaid and CHP 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).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that you were not eligible for Medicaid, as of your November 27, 2017 application.

You updated your NYSOH application on July 17, 2017, and indicated that you were pregnant and expecting one child on [REDACTED]. You were found fully eligible for Medicaid in a determination issued by NYSOH on July 18, 2017. That eligibility was not appealed, and is not under review.

On September 21, 2017, NYSOH issued a notice stating that it was time to renew your child's application for health insurance. On October 3, 2017, you updated your NYSOH account.

After this application update, NYSOH issued a notice of eligibility determination that stated that you were eligible for Medicaid coverage for all outpatient prenatal Medicaid services, effective November 1, 2017. This is known as “presumptive Medicaid eligibility.” The notice further directed you to submit documentation of your household income by October 18, 2017.

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Pregnant women who apply for Medicaid, and whose financial eligibility is not confirmed, will be eligible for presumptive Medicaid only, until the woman's eligibility for full Medicaid can be determined. Presumptive Medicaid eligibility covers prenatal care only, as a matter of policy.

Had you been without coverage, or enrolled in non-Medicaid coverage, prior to your October 3, 2017 application update, your Medicaid eligibility would have properly been presumptive, as NYSOH needed to verify your financial eligibility.

However, you were already receiving full Medicaid when you updated your application on October 3, 2017, as stated in the July 18, 2017 eligibility determination.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, unless the person fails to provide a valid Social Security number or citizenship status, loses state residence, or enters a prison or other facility that provides medical care. This provision is called "continuous coverage."

Credible evidence confirms that you were eligible for Medicaid effective September 1, 2017. There is no evidence in the record that your coverage should have changed or ended when you updated your application on October 3, 2017, and your coverage should therefore not have changed to presumptive coverage. Additionally, when you updated your application on November 27, 2017, even though the income listed in your application increased, you should have remained eligible for Medicaid until August 31, 2018, barring any subsequent changes that would make you ineligible.

Therefore, the October 4, 2017 eligibility determination is MODIFIED to state that you remained eligible for full Medicaid, effective November 1, 2017. Additionally, the November 28, 2017 eligibility determination is MODIFIED to state that you are no longer eligible for Medicaid, but that your Medicaid coverage will continue until August 31, 2018, barring any subsequent change in your circumstances that would make you ineligible, because of continuous coverage.

The October 4, 2017 disenrollment notice, ending your enrollment in your MMC plan as of October 31, 2017 is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in full Medicaid coverage beginning November 1, 2017, and continuing through August 31, 2018, barring any subsequent change in your circumstances that would make you ineligible.

Additionally, your case is RETURNED to NYSOH to permit you to enroll in an MMC plan, beginning on November 1, 2017, or a later date of your choosing, as your MMC plan enrollment should not have terminated on October 31, 2017.

The second issue under review is whether NYSOH properly determined that your child was eligible to enroll in CHP at full cost, effective January 1, 2018.

According to the record, you expect to file a joint federal income tax return for the 2018 tax year and claim your one child as a dependent. However, you are also pregnant and expecting one child [REDACTED]. Therefore, your child is in a four-person household.

In your November 27, 2017 application, you attested to an expected household income of \$84,238.00. You also provided income documentation to NYSOH on that day. NYSOH reviewed the documentation, which was a copy of your 2016 federal income tax return showing an adjusted gross income of \$109,234.00, and updated your application utilizing this income figure. The application also stated that your child is one year old.

A child is eligible to enroll in CHP if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income over 400% of the FPL are responsible for the full monthly CHP premium payment, and are not eligible for a subsidized premium. On the date of your application, the relevant FPL was \$24,600.00 for a four-person household. Since \$109,234.00 is 444.04% of the 2017 FPL, NYSOH properly found your child to be eligible to enroll in CHP at full cost, effective January 1, 2018, based on the income documentation you provided.

Therefore, the November 28, 2017 eligibility determination, insofar as it stated that your child was eligible to enroll in a full cost CHP plan, effective January 1, 2018, is **AFFIRMED**.

However, at the hearing, you testified that you provided your 2017 business earnings and expenses to a CPA, and that the CPA calculated that your adjusted gross income for 2017 was \$96,323.00. After the hearing, you provided a letter from your CPA dated January 19, 2018 showing that your 2017 adjusted gross income, after deductions for \$25,000.00 in IRA contributions and \$9,223.00 in self-employment tax, is expected to be \$96,323.00. As you testified that you believe your 2018 income will be similar, your case is **RETURNED** to NYSOH to redetermine your child's eligibility for financial assistance for 2018 based on a four-person household with an expected annual income of \$96,323.00.

## **Decision**

The October 4, 2017 eligibility determination is **MODIFIED** to state that you continued to be eligible for Medicaid, effective November 1, 2017.

The October 4, 2017 disenrollment notice is **RESCINDED**.

The November 28, 2017 eligibility determination is MODIFIED to state that you are no longer eligible for Medicaid, but that your Medicaid coverage will continue until August 31, 2018, barring any subsequent changes in your eligibility.

The November 28, 2017 eligibility determination is AFFIRMED, only insofar as it stated that your child was eligible to enroll in a CHP plan at full cost, effective January 1, 2018.

Your case is RETURNED to NYSOH to reinstate you in full Fee-For-Service Medicaid beginning November 1, 2017, and continuing until August 31, 2018, barring any subsequent changes in your eligibility.

Your case is RETURNED to NYSOH to assist you in enrolling in an MMC plan, beginning on November 1, 2017 or a later date of your choosing.

Your case is RETURNED to NYSOH to redetermine your child's eligibility for financial assistance, effective January 1, 2018, based on a four-person household with an expected annual income of \$96,323.00.

**Effective Date of this Decision: February 21, 2018**

### **How this Decision Affects Your Eligibility**

Your Medicaid coverage, which began on September 1, 2017, should have continued for a twelve-month period, regardless of your October 3, 2017 and November 27, 2017 application updates.

Your eligibility should not have been changed to presumptive eligibility as of November 1, 2017.

Your case is being sent back to NYSOH to reinstate you in full Medicaid as of November 1, 2017, and to continue your Medicaid coverage until August 31, 2018, unless there are any subsequent changes in your eligibility.

You should not have been disenrolled from your MMC plan as of October 31, 2017. Your case is being sent back to NYSOH to assist you in re-enrolling in an MMC plan beginning November 1, 2017, or a later date of your choosing.

NYSOH properly determined that your child was eligible to enroll in a CHP plan at full cost, effective January 1, 2018, based on the income documentation you provided.

Your case is being sent back to NYSOH to redetermine your child's eligibility for financial assistance for 2018, based on the updated income information you provided during and after the hearing.

## **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 October 4, 2017 eligibility determination is MODIFIED to state that you continued to be eligible for Medicaid, effective November 1, 2017.

The October 4, 2017 disenrollment notice is RESCINDED.

The November 28, 2017 eligibility determination is MODIFIED to state that you are no longer eligible for Medicaid, but that your Medicaid coverage will continue until August 31, 2018, barring any subsequent changes in your eligibility.

The November 28, 2017 eligibility determination is AFFIRMED, only insofar as it stated that your child was eligible to enroll in a CHP plan at full cost, effective January 1, 2018.

Your case is RETURNED to NYSOH to reinstate you in full Fee-For-Service Medicaid beginning November 1, 2017, and continuing until August 31, 2018, barring any subsequent changes in your eligibility.

Your case is RETURNED to NYSOH to assist you in enrolling in an MMC plan, beginning on November 1, 2017 or a later date of your choosing.

Your case is RETURNED to NYSOH to redetermine your child's eligibility for financial assistance, effective January 1, 2018, based on a four-person household with an expected annual income of \$96,323.00.

Your Medicaid coverage, which began on September 1, 2017, should have continued for a twelve-month period, regardless of your October 3, 2017 and November 27, 2017 application updates.

Your eligibility should not have been changed to presumptive eligibility as of November 1, 2017.

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Your case is being sent back to NYSOH to reinstate you in full Medicaid as of November 1, 2017, and to continue your Medicaid coverage until August 31, 2018, unless there are any subsequent changes in your eligibility.

You should not have been disenrolled from your MMC plan as of October 31, 2017. Your case is being sent back to NYSOH to assist you in re-enrolling in an MMC plan beginning November 1, 2017, or a later date of your choosing.

NYSOH properly determined that your child was eligible to enroll in a CHP plan at full cost, effective January 1, 2018, based on the income documentation you provided.

Your case is being sent back to NYSOH to redetermine your child's eligibility for financial assistance for 2018, based on the updated income information you provided during and after the hearing.

## **Legal Authority**

We are sending you this notice in accordance with 45 CFR § 155.545.

**A Copy of this Decision Has Been Provided To:**



## 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 مجاناً.

### 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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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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