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

Notice of Decision

Decision Date: April 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026986

[redacted]

[redacted],

On March 27, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 3, 2018 plan enrollment; January 18, 2018 eligibility determination and January 18, 2018 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: April 26, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000026986

Issues

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

> Did NY State of Health (NYSOH) properly enroll you in a Medicaid Managed Care (MMC) plan with an enrollment start date of February 1, 2018?
>
> Did NYSOH properly determine that you were no longer qualified for Medicaid and properly end your MMC coverage as of January 31, 2018?

Procedural History

On December 30, 2017, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid, effective as of December 1, 2017. The notice instructed you to submit proof of your Benefit Information for Third Party Health Insurance by January 13, 2018.

On January 3, 2018, NYSOH issued a plan enrollment notice confirming that as of January 2, 2018, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of February 1, 2018.

On January 9, 2018, you spoke with NYSOH's Account Review Unit and requested an appeal relative to the enrollment start date of the MMC plan.

On January 13, 2018, you faxed income documentation to your NYSOH account (*see* Documents

On January 17, 2018, your NYSOH account was updated.

On January 18, 2018, NYSOH issued an eligibility determination notice stating, in relevant part, that you no longer qualified for Medicaid as of January 31, 2018, because the household income of $72,909.79 was over the income limit of $36,216.00.

Also on January 18, 2018, NYSOH issued a disenrollment notice stating that your MMC coverage would end on February 1, 2018, because you were no longer eligible to enroll in that health plan.

On March 27, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until April 10, 2018, to allow you to submit: (1) 2017 Form 1040 Schedule C; (2) December 2017 pay statements; and (3) a termination letter of your third-party health insurance coverage.

On April 9, 2018 and April 11, 2018, you sent three faxes to NYSOH's Appeals Unit (Documents [redacted]). The faxes contained sixteen-pages of documentation. The documentation has been made part of the record, and the record is now complete and closed.

Findings of Fact

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

1) You testified that you are appealing the enrollment start date of your MMC and discontinuance of your Medicaid coverage.

2) According to your NYSOH account and testimony, you are applying for health insurance for yourself.

3) According to your NYSOH account and testimony, you expect to file a 2018 federal income tax return with the tax status of single, and do not expect to claim any dependents on that tax return.

4) According to your NYSOH account, you are pregnant with a due date of [redacted].

5) You testified that you [redacted] at the end of [redacted] and are no longer pregnant.

6) According to your December 29, 2017 application, you expected earned income of $34,000.00, and business expenses of $10,000.00 in 2018.

7) According to your NYSOH account, your expected annual household income was calculated to be $24,000.00.

8) According to your NYSOH account, on January 2, 2018, you enrolled in a MMC plan.

9) According to your NYSOH account, you are enrolled in an employer-sponsored health plan.

10) You testified that, in November 2017, you enrolled in a health plan, through Oscar, and the plan was to be effective January 1, 2018. You cancelled the plan and the cancellation date was December 31, 2017.

11) On April 9, 2018, you submitted from Oscar a confirmation of termination letter to NYSOH's Appeals Unit. The letter, dated April 3, 2018, states that you voluntarily terminated your coverage, and the termination was effective December 31, 2017 (*see* Document [redacted].

12) You testified that you are an [redacted] with [redacted] and that has been your only source of income since August 21, 2017.

13) On January 13, 2018, you faxed four pay statements from [redacted] to NYSOH. You were issued total payouts of:

    (1) $1,326.56 for the period ending December 18, 2017;
    (2) $952.46 for the period ending December 25, 2017;
    (3) $634.63 for the period ending January 1, 2018;
    (4) $653.80 for the period ending January 8, 2018;

    (*see* Documents [redacted] uploaded 1/16/2018).

14) According to your NYSOH account, on January 17, 2018, NYSOH calculated your expected earned income to be $82,909.79 and your deductions to be $10,000.00.

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

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Applicable Law and Regulations

MMC Enrollment Start Date

Medicaid Managed Care plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; *see* 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

Medicaid – Household Size

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 – Pregnant Women

Medicaid is 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).

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 2018 FPL, which is $16,460.00 for a two-person household (83 Fed. Reg. 2642).

Legal Analysis

The first issue under review is whether NYSOH properly enrolled you in a MMC plan with an enrollment start date of February 1, 2018.

The date on which a MMC plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected from the first day to and including the fifteenth day of a month will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

The record supports that on January 2, 2018, you contacted NYSOH and enrolled in a MMC plan.

Since the MMC plan was selected on January 2, 2018, you were properly enrolled in that plan on the first day of the following month; that is, as of February 1, 2018.

Therefore, the January 3, 2018 plan enrollment notice is AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were no longer eligible for Medicaid and ended your MMC coverage as of January 31, 2018.

The record reflects that on December 29, 2017, you applied for health insurance through NYSOH. In that application, you attested that you expected to earn $34,000.00 and deduct $10,000.00 in business expenses in 2018. Based on your attestations, your expected annual household income was calculated to be $24,000.00.

Based on that application, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid and instructed you to submit proof of your Benefit Information for your third-party health insurance by January 13, 2018.

When determining an individual's eligibility for Medicaid, the household size of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver. The record reflects that you were pregnant during the months of [REDACTED] and [REDACTED]. Therefore, you were in a two-person household.

Medicaid can be provided to pregnant woman who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 223% of the FPL for the applicable household size, which is an annual income of $36,706.00 for a two-person household.

On January 13, 2018, you faxed four pay statements from your only source of income, [redacted], to NYSOH. You were issued total payouts of: (1) $1,326.56 for the period ending December 18, 2017; (2) $952.46 for the period ending December 25, 2017; (3) $634.63 for the period ending January 1, 2018; and (4) $653.80 for the period ending January 8, 2018 (*see* Documents [redacted]

On January 17, 2018, NYSOH attempted to recalculate your income using the documentation submitted on January 13, 2018. NYSOH calculated your expected earned income to be $82,909.79 and your deductions to be $10,000.00. Based on that recalculation, on January 18, 2018, NYSOH issued an eligibility determination notice stating that you no longer qualified for Medicaid as of January 31, 2018, because the household income of $72,909.79 was over the income limit

Based on the documentation submitted, NYSOH should have calculated your expected earned income to be ($1,326.56 + $952.46 + $634.63 + $653.80) X 13 periods) $46,376.85, and your business deductions to be $10,000.00. Therefore, your expected annual household income is ($46,376.85 - $10,000.00) $36,376.85.

Medicaid is available to pregnant women who have a modified adjusted gross income at or below 223% of the 2018 FPL for a two-person household, which is $36,706.00 annually.

Based on the information available to NYSOH as of January 17, 2018, your expected 2018 annual income was $36,376.85 and did not exceed the maximum allowable amount of $36,706.00. Therefore, NYSOH incorrectly determined that you no longer qualified for Medicaid and ended your MMC coverage as of January 31, 2018.

The January 18, 2018 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC plan coverage as of February 1, 2018.

Your NYSOH account reflects that you were enrolled in an employer-sponsored health insurance plan, through Oscar, and the plan was to be effective January 1, 2018. However, you testified that you had cancelled the plan with a cancellation date of December 31, 2017. Further, you submitted a letter from Oscar stating that you voluntarily terminated your coverage, and the termination would be effective December 31, 2017 (*see* Document [redacted]

Your case is RETURNED to NYSOH to update your account to reflect that you were no longer enrolled in employer-sponsored insurance as of December 31, 2017.

According to your NYSOH account, you are pregnant with a due date of [redacted] [redacted]; however, you testified that you [redacted] at the end of [redacted] [redacted] and are no longer pregnant.

Your case is RETURNED to NYSOH to update your account to reflect that you are no longer pregnant.

Decision

The January 3, 2018 plan enrollment notice is AFFIRMED.

The January 18, 2018, eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC plan coverage as of February 1, 2018.

Your case is RETURNED to NYSOH to update your account to reflect that you were no longer enrolled in employer-sponsored insurance as of December 31, 2017.

Your case is RETURNED to NYSOH to update your account to reflect that you are no longer pregnant.

Effective Date of this Decision: April 26, 2018

How this Decision Affects Your Eligibility

NYSOH properly enrolled you in a MMC plan with an enrollment start date of February 1, 2018.

NYSOH improperly determined you to be ineligible for Medicaid and ended your MMC coverage on the basis that your income exceeded the allowable income threshold, which was the result of NYSOH's miscalculation of your income.

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 January 3, 2018 plan enrollment notice is AFFIRMED.

The January 18, 2018, eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your MMC plan coverage as of February 1, 2018.

Your case is RETURNED to NYSOH to update your account to reflect that you were no longer enrolled in employer-sponsored insurance as of December 31, 2017.

Your case is RETURNED to NYSOH to update your account to reflect that you are no longer pregnant.

NYSOH properly enrolled you in a MMC plan with an enrollment start date of February 1, 2018.

NYSOH improperly determined you to be ineligible for Medicaid and ended your MMC coverage on the basis that your income exceeded the allowable income threshold, which was the result of NYSOH's miscalculation of your income.

Legal Authority

We are issuing this determination in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

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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)

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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।

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.

(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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