



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

Notice of Decision

Decision Date: April 24, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000028652

[REDACTED]

[REDACTED],

On April 9, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 20, 2018 eligibility determination and 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 NY State of Health Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY - Spanish: 1-877-662-4886).

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NY State of Health Account ID: [REDACTED]
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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 eligible for Medicaid, effective January 1, 2018?

Did NYSOH properly determine that your enrollment in your Essential Plan ended, effective December 31, 2017?

Procedural History

On January 19, 2018, you submitted an updated application for financial assistance with health insurance.

On January 20, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective January 1, 2018. The notice also stated that you were no longer qualified for the Essential Plan as of December 31, 2017.

Also on January 20, 2018, NYSOH issued a disenrollment notice stating that your Essential Plan coverage would end on January 31, 2018.

On January 30, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan was effective March 1, 2018.

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On February 8, 2018, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination notice insofar as you were not eligible for the Essential Plan.

On April 9, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

- 1) You testified that you expect to file your tax return for 2018 with a tax filing status of head of household. You will claim one dependent on that tax return.
- 2) You are seeking insurance for yourself, specifically the Essential Plan as of January 1, 2018.
- 3) The application submitted on January 19, 2018 states that you were pregnant with one child, with a due date of [REDACTED]. You testified that this is correct.
- 4) The application that was submitted on January 19, 2018, listed annual household income of \$29,120.00, consisting of income you earn from your employment. You testified that this amount was correct.
- 5) Your application states that you will not be taking any deductions on your 2018 tax return.
- 6) Your application states that you live in Westchester County, NY.
- 7) The enrollment tab in your NYSOH account indicates that your Essential Plan coverage was terminated as of December 31, 2017.
- 8) You testified that you are seeking the Essential Plan as of January 1, 2018, because you have outstanding bills for pregnancy related medical services rendered that are not covered by Medicaid Fee-For-Service.

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)).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

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)).

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 \$20,420.00 for a three-person household (82 Fed. Reg. 8831).

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).

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-

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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)).

Essential Plan – Eligibility Redetermination

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any updates in eligibility to the Essential Plan effective the first day of the following month for changes received by NYSOH from the first to the fifteenth of any month (45 CFR § 155.420(b)(1)(i); see also 42 CFR § 600.320(c)). For updates received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR § 155.420(b)(1)(ii); see also 42 CFR § 600.320(c)).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for Medicaid, effective January 1, 2018.

The application that was submitted on January 19, 2018 listed an annual household income of \$29,120.00 and the eligibility determination relied upon that information. You expect to file your 2018 income taxes as head of household and will claim one dependent on that tax return.

When calculating family size for Medicaid purposes, 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. On the date of your January 19, 2018 application, you were pregnant with one child. Consequently, NYSOH determined your eligibility for Medicaid using a three-person household.

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 \$20,420.00 for a three-person household. Since \$29,120.00 is 142.61% of the 2017 FPL, you were properly determined eligible for Medicaid based on an expected annual income basis, using the information provided in your application.

Since the January 20, 2018 eligibility determination notice properly stated that, based on the information you provided, you were eligible for Medicaid, it is correct and is AFFIRMED.

The second issue under review is whether NYSOH properly determined that your enrollment in your Essential Plan coverage ended, effective December 31, 2017.

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You updated your NYSOH account on January 19, 2018. As a result, you were found newly eligible for Medicaid, and no longer eligible for the Essential Plan.

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any updates in eligibility to the Essential Plan effective the first day of the following month for changes received by NYSOH from the first to the fifteenth of any month. For updates received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure changes are effective the first day of the second following month.

You updated your application on January 19, 2018. Therefore, any changes in your Essential Plan eligibility resulting from that update should not have gone into effect until the first day of the second month following January 2018. This means your enrollment in your Essential Plan coverage should not have ended until February 28, 2018.

Therefore, the January 20, 2018 disenrollment notice is MODIFIED to state that your enrollment in your Essential Plan coverage ended as of February 28, 2018.

Your case is RETURNED to NYSOH to reinstate you in your Essential Plan for the months of January 2018 and February 2018, and to notify you when this has been done.

Decision

The January 20, 2018 eligibility determination notice is AFFIRMED.

The January 20, 2018 disenrollment notice is MODIFIED to state that your enrollment in your Essential Plan ended as of February 28, 2018.

Your case is RETURNED to NYSOH to reinstate you in your Essential Plan coverage for the months of January 2018 and February 2018.

Effective Date of this Decision: April 24, 2018

How this Decision Affects Your Eligibility

This decision does not change your current eligibility.

You were properly determined eligible for Medicaid, effective January 1, 2018.

You should have remained enrollment in your Essential Plan coverage until February 28, 2018.

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).

Your case is being sent back to NYSOH to reinstate you in your Essential Plan coverage for the months of January 2018 and February 2018.

You will be responsible for any premium payments that result from the backdating of your coverage.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 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 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 20, 2018 eligibility determination notice is **AFFIRMED**.

This decision does not change your current eligibility.

You were properly determined eligible for Medicaid, effective January 1, 2018.

The January 20, 2018 disenrollment notice is **MODIFIED** to state that your enrollment in your Essential Plan ended as of February 28, 2018.

You should have remained enrollment in your Essential Plan coverage until February 28, 2018.

Your case is **RETURNED** to NYSOH to reinstate you in your Essential Plan coverage for the months of January 2018 and February 2018.

You will be responsible for any premium payments that result from the backdating of your coverage.

Legal Authority

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

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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 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।

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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 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&btumi 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.