



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

## Notice of Decision

Decision Date: November 25, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000008955

[REDACTED]

Dear [REDACTED]

On November 15, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's January 29, 2016, March 19, 2016, April 16, 2016, and April 19, 2016 eligibility determinations.

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 25, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000008955

[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 your son was eligible for Medicaid effective January 1, 2016?

Did NYSOH properly determine that your son was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until February 28, 2017?

## Procedural History

On January 29, 2016, NYSOH issued a notice of eligibility determination stating that your son was conditionally eligible for Medicaid because your household income of \$0.00 was at or below the allowable income limit. This eligibility was effective as of January 1, 2016.

On March 17, 2016, your NYSOH application was updated.

On March 19, 2016, NYSOH issued a notice of eligibility determination stating that your son remained eligible for Medicaid, effective March 1, 2016.

On April 15 and 18, 2016, NYSOH received your updated applications for health insurance; specifically the income information was updated on each of these dates.

On April 16, 2016, NYSOH issued a notice of eligibility determination stating that your son was no longer eligible for Medicaid. However, his Medicaid coverage would continue until February 28, 2017 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of April 1, 2016.

On April 18, 2016, NYSOH prepared a preliminary eligibility determination stating that your son was no longer eligible for Medicaid, but that his coverage would continue until February 28, 2017.

That same day, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as your son's Medicaid coverage was continued and you were not able to put him on your health insurance coverage with a subsidy.

On April 19, 2016, NYSOH issued a notice of eligibility determination stating that your son was no longer eligible for Medicaid. However, his Medicaid coverage would continue until February 28, 2017.

On November 15, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. A Mandarin language interpreter, ID [REDACTED] assisted provided interpreter services for the hearing. 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 2016 federal income tax return as head of household, and claim two dependents.
- 2) According to the January 28, 2016 application, you attested to an expected annual household income of \$0.00. You testified that this income was not an accurate representation of your household income.
- 3) You testified that a broker completed the application with you because you do not speak English, and that the broker must have mistakenly entered your income as "0.00."
- 4) You testified that you realized in April 2016 that you and your son were not being asked to pay for your health coverage, and you did not believe that could be correct.

- 5) You testified that you went to a new individual for assistance with updating your NYSOH application, and that you believe it was someone from a health plan who assisted you in updating your account in April 2016.
- 6) According to the April 18, 2016 application, you attested to an increased expected household income of \$40,500.00. You testified that this amount is correct, and that it is income from an account that you have in China. You testified that this income amount should have been entered into your January 2016 application.
- 7) According to your NYSOH account, you had a household size of two at the time of your January 2016 application, but your household size was increased to three when you added your daughter to your account on April 18, 2016.
- 8) You testified that you requested this appeal because you were concerned that your son was receiving a benefit that he was not entitled to.
- 9) You testified that you would like to be able to add your son to your health plan.
- 10) Your account reflects that you reside in Nassau County.

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

## **Applicable Law and Regulations**

### Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York Department of Social Services Administrative Directive 13ADM-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 2016 FPL, which is \$16,020.00 for a two-person household (81 Federal Register 4036).

Most children determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage even if they lose Medicaid eligibility because of any changes

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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, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined your son was eligible for Medicaid effective January 1, 2016.

Your January 2016 application reflected that you were in a two-person household. According to the January 2016 application, you expected to file your 2016 tax return as head of household and claim your son as a dependent.

On your January 28, 2016 application, you attested to an expected household income of \$0.00.

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$16,020.00 for a two-person household. Since \$0.00 is 0% of the 2016 FPL, NYSOH properly found your son to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, you testified the income listed on that application was not correct because the broker you worked with mistakenly entered your income as \$0.00, when it should have been \$40,500.00. You further testified that when you realized the mistake, you attempted to correct your application, and your NYSOH account reflects that your application was updated to reflect this income amount on April 18, 2016.

Therefore, your household income at the time of the January 28, 2016 application was \$40,500.00. Since \$40,500.00 is 252.81% of the 2016 FPL, it is greater than the allowable Medicaid limit, and the January 29, 2016 and March 19, 2016 eligibility determination notices finding your son eligible for Medicaid are not supported by the record and are **RESCINDED**.

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The second issue is whether NYSOH properly determined that your son was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until February 28, 2017.

Once a person is found eligible for Medicaid, they remain eligible for Medicaid for 12 continuous months whether or not their income increases. This is referred to as “continuous coverage.”

Since the January 29 and March 19, 2016 eligibility determinations were issued based on incorrect information and are not supported by the record, and there was no other determination finding your son eligible for Medicaid, the continuous coverage policy should not have been applied to your son. Therefore, the April 16 and April 19, 2016 eligibility determination notices are also RESCINDED.

Your case is RETURNED to NYSOH to redetermine your son’s eligibility for financial assistance, based on a household of 3 with an annual expected income of \$40,500.00, residing in Nassau County.

## **Decision**

The January 29, March 29, April 16, and April 19, 2016 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your son’s eligibility based on a three-person household, residing in Nassau County with an expected annual income of \$40,500.00.

**Effective Date of this Decision:** November 25, 2016

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

Your son was incorrectly found eligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your son’s eligibility based on the information presented during the hearing. You will receive an eligibility determination notice informing you of your son’s new eligibility.

## **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 29, March 29, April 16, and April 19, 2016 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your son's eligibility based on a three-person household, residing in Nassau County with an expected annual income of \$40,500.00.

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 son was incorrectly found eligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your son's eligibility based on the information presented during the hearing. You will receive an eligibility determination notice informing you of your son's new eligibility.

### **Legal Authority**

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

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

