



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

## Notice of Decision

Decision Date: March 24, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013683



Dear [REDACTED]

On March 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 8, 2016 and December 1, 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: March 24, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013683



## 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 October 1, 2016?

Did NY State of Health properly determine that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until September 30, 2017?

## Procedural History

On October 8, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of \$0.00 was at or below the allowable income limit. This eligibility was effective as of October 1, 2016.

On November 30, 2016, NYSOH received your updated application for health insurance; specifically, the income information was updated. That day, a preliminary eligibility determination was prepared with regard to that application, stating that you were no longer eligible for Medicaid, however your Medicaid coverage would continue, because certain individuals determined eligible for Medicaid remain eligible for benefits for twelve months from the date that they were determined eligible.

Also on November 30, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as your

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Medicaid coverage was continued and you were not found eligible for another insurance program.

On December 1, 2016, NYSOH issued a notice of eligibility determination, based on the November 30, 2016 application, stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until September 30, 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 November 1, 2016.

On March 6, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for 15 days to allow you the opportunity to submit income documentation for September 2016 and October 2016.

On March 8, 2017 you uploaded documentation of your income for September 2016 and October 2016 (Doc. ID # [REDACTED]). This document is marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

## **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 single, and claim no dependents.
- 2) According to the September 29, 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 at the time of your September 29, 2016 application you were not sure what your 2017 annual expected income was and that your income in 2015 was \$0.00. You further explained that you are self-employed, hosting an Air BNB and dog sitting, and that your income varies.
- 4) You testified that once you had a more accurate indication of your income, you contacted NYSOH.
- 5) According to the November 30, 2016 application, you attested to an increased expected household income of \$16,500.00.
- 6) You testified that your 2016 income was \$16,799.39 and that you expect your 2017 income to be around \$16,800.00.

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- 7) You provided documentation stating that your income in September 2016 was \$1,733.20 and your income in October 2016 was \$1,155.86.
- 8) Your application indicates that you reside in Monroe County.

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 through NYSOH can be provided 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 2016 FPL, which is \$22,880.00 for a one-person household (81 Federal Register 4036).

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, 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 that you were eligible for Medicaid effective October 1, 2016.

You are in a one-person household. According to the record, you expect to file your 2016 tax return as single and claim no dependents.

On your September 29, 2016 application, you attested to an expected household income of \$0.00.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 64 who meet the non-financial requirements and have a household MAGI that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$11,880.00 for a one-person household. Since \$0.00 is 0% of the 2016 FPL, NYSOH properly found you 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 you are self-employed and your income varies. You further testified that when you had accurate income information, you attempted to correct your application. You provided documentation that shows in September 2016 your income was \$1,733.20 and in October 2016 your income was \$1,155.86. You also testified that your annual income for 2016 was \$16,799.39.

Therefore, your household income at the time of the September 29, 2016 application was \$16,799.39. Since \$16,799.39 is 141.41% of the 2016 FPL, it is greater than the allowable Medicaid limit, and the October 8, 2016 eligibility determination notice finding you eligible for Medicaid is not supported by the record and is **RESCINDED**.

The second issue is whether NYSOH properly determined that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until September 30, 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 October 8, 2016 eligibility determination was issued based on incorrect information and is not supported by the record, and there was no other

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determination finding you eligible for Medicaid, the continuous coverage policy should not have been applied to you. Therefore, the December 1, 2016 eligibility determination notice is also RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household, residing in Monroe County with an expected annual income of \$16,800.00.

## **Decision**

The October 8, 2016 and December 1, 2016 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household, residing in Monroe County with an expected annual income of \$16,800.00.

**Effective Date of this Decision:** March 24, 2017

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

You were incorrectly found eligible for Medicaid.

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

## **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

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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 8, 2016 and December 1, 2016 eligibility determination notices are **RESCINDED**.

You were incorrectly found eligible for Medicaid.

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Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household, residing in Monroe County with an expected annual income of \$16,800.00.

### **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।

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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&etumi ama wo obi a okyerε 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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