



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

Notice of Decision

Decision Date: November 29, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000021936

[REDACTED]

[REDACTED]

On October 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 3, 2017 renewal notice and August 30, 2017 eligibility determination notice.

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 Date: November 29, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000021936

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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 properly determine that you were eligible for Medicaid effective August 1, 2017?

Did NY State of Health properly determine that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until July 31, 2018?

Procedural History

On June 26, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan, effective August 1, 2016.

On June 2, 2017, NYSOH submitted an application on your behalf based on income information from federal and state data sources.

On June 3, 2017, NYSOH issued a renewal notice stating that you were eligible for Medicaid because federal and state data sources show that your income was at or below the allowable income limit. This eligibility was effective as of August 1, 2017.

On August 29, 2017, 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,

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stating that although you were no longer eligible for Medicaid, your Medicaid would continue until July 31, 2018.

Also on August 29, 2017, you contacted NYSOH's Account Review Unit and appealed that determination insofar as your Medicaid coverage was continued and you were not found eligible for another insurance program.

On August 30, 2017, NYSOH issued a notice of eligibility determination, based on the August 29, 2017 application, stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until July 31, 2018 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 August 1, 2017.

On October 27, 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 twenty-one days to allow you time to submit supporting documentation. No documentation was received within the allotted time. 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 2017 federal income tax return as single, and will not claim any dependents on that return.
- 2) You testified that the adjusted gross income on your 2016 tax return was \$3,345.00. You explained that your annual expected income for 2017 has changed as in 2016 you were in school, and now you are working full-time.
- 3) You explained that you work [REDACTED] as well as receiving a regular wage from [REDACTED].
- 4) You testified, and your NYSOH account reflects, that you have elected to receive all of your notices from NYSOH via electronic mail.
- 5) You testified that you are not sure if you received the June 3, 2017 renewal notice stating that you were eligible for Medicaid.
- 6) You went on to testify that you did not know that you were enrolled in Medicaid until the end of August 2017.

- 7) You testified that as soon as you realized that you had been found eligible for Medicaid, you contacted NYSOH to update your application.
- 8) According to the August 29, 2017 application, you attested to an increased expected household income of \$24,000.00.
- 9) You testified that you expect to claim \$3,000.00 in business expense deductions for 2017.
- 10) You testified that you reside in [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 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 2017 FPL, which is \$12,060.00 for a one-person household (82 Fed. Reg. 8831).

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 August 1, 2017.

According to the record, you expect to file your 2017 tax return as single and will not claim any dependents on that return. Therefore, you are in a one-person household.

On June 2, 2017, NYSOH determined your eligibility for financial assistance with health insurance, based on information from federal and state data sources.

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 \$12,060.00 for a one-person household. Since federal and state data sources showed that your income was between \$0.00 and \$16,643.00, NYSOH properly found you to be eligible for Medicaid on an expected annual income basis, using the available information.

However, you testified the income information that NYSOH received from federal and state data sources was no longer correct because you were no longer enrolled in school and were working on a full-time basis. You further testified that when you realized that you had been found eligible for Medicaid, you attempted to correct your application.

You credibly testified that your annual expected income for 2017 is \$24,000.00 less \$3,000.00 in business expense deductions.

Therefore, your household income at the time of the June 2, 2017 application was \$21,000.00. Since \$21,000.00 is 174.13% of the 2017 FPL, it is greater than the allowable Medicaid limit, and the June 3, 2017 renewal 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 July 31, 2018.

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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 June 3, 2017 renewal notice was issued based on incorrect information and is not supported by the record, and there was no other determination finding you eligible for Medicaid, the continuous coverage policy should not have been applied to you. Therefore, the August 30, 2017 eligibility determination notice is also RESCINDED.

Decision

The June 3, 2017 renewal notice is RESCINDED.

The August 30, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household, residing in Kings County with an expected annual income of \$21,000.00.

Effective Date of this Decision: November 29, 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.

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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 June 3, 2017 renewal notice is **RESCINDED**.

The August 30, 2017 eligibility determination notice is **RESCINDED**.

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You were incorrectly found eligible for Medicaid.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household, residing in Kings County with an expected annual income of \$21,000.00.

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.

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 مجاناً.

(Bengali)

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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. yeb&tumi ama wo obi a okyer& 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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