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

Notice of Decision

Decision Date: March 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025181

[redacted]

Dear [redacted]

On February 14, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 21, 2017, November 28, 2017, and December 1, 2017 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: March 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025181

[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 you were eligible for Medicaid, effective November 1, 2017?
>
> Did NYSOH properly determine that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until October 31, 2018?

Procedural History

On November 17, 2017, NYSOH received your updated application for financial assistance with your health insurance. In that application you attested to an expected annual household income of $26,000.00.

Also on November 17, 2017, you uploaded to your NYSOH account a copy of your 2016 income tax return.

On November 18, 2017, NYSOH issued an eligibility determination notice, based on the November 17, 2017 updated application, stating that you were conditionally eligible to receive up to $367.00 in advance payments of the premium tax credit (APTC), and conditionally eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, both effective January 1, 2018. The notice further directed you to provide documentation confirming your income before February 15, 2018.

Also on November 18, 2017, NYSOH issued a notice confirming your enrollment in a gold-level qualified health plan with APTC and cost-sharing reductions, effective January 1, 2018.

On November 20, 2017, the income documentation you submitted was reviewed and verified. NYSOH adjusted your expected household income from $26,000.00 down to $2,379.00 and an updated application for financial assistance was submitted on your behalf.

On November 21, 2017, NYSOH issued an eligibility determination notice, based on the November 20, 2017 application, stating that you were eligible for Medicaid because your household income of $2,379.00 was at or below the allowable income limit. This eligibility was effective as of November 1, 2017.

Also on November 21, 2017, NYSOH issued a disenrollment notice stating that your gold-level qualified health plan would end on January 1, 2018. This was because you were no longer eligible to enroll in that plan.

On November 27, 2017 and November 30, 2017 NYSOH received your updated applications for financial assistance with your health insurance. In those applications you attested to an expected annual household income of $26,000.00.

On November 28, 2017 and December 1, 2017, NYSOH issued eligibility determination notices based on the November 27, 2017 and November 30, 2017 updated applications, stating that you were no longer eligible for Medicaid. The December 1, 2017 eligibility determination also stated that your Medicaid coverage would continue until October 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. These eligibility determinations were effective as of January 1, 2018.

On December 1, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of those eligibility determinations insofar as your Medicaid coverage was continued and you were not found eligible for another insurance program.

On February 14, 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 expect to file your 2018 federal income tax return as single and will claim no dependents.

2) According to the November 17, 2017 application, you attested to an expected annual household income of $26,000.00. You testified that you are a [redacted] in [redacted]. You testified that you earn your income from your share of capital gains from sale of properties and dividends from investments.

3) According to your November 17, 2017, November 27, 2017 and November 30, 2017 applications for health insurance you expect to receive $2,000.00 in taxable interest and $24,000.00 in rental income, royalties, partnerships, S-Corps, trusts and capital gains. You testified that these are accurate estimates of your expected income.

4) The record reflects that you uploaded a copy of your 2016 income tax return on November 17, 2017. On November 20, 2017, NYSOH verified that document and adjusted your income from $26,000.00 down to $2,379.00 which was the adjusted gross income amount listed on that return.

5) You testified that the 2016 income tax return is not an accurate reflection of your expected income because your income can vary from year to year.

6) The record reflects that on November 20, 2017, NYSOH submitted an application on your behalf based on the adjusted income of $2,379.00 and you were determined eligible for Medicaid effective November 1, 2017.

7) You testified that when you received the November 21, 2017 notice you immediately uploaded a letter to NYSOH stating that you are a [redacted] and that your income fluctuates yearly. The letter stated you did not want Medicaid and wanted to be reenrolled in your gold-level qualified health plan (see Document # [redacted]).

8) According to the November 27, 2017 and November 30, 2017 updated applications you again attested to an expected income of $26,000.00 based on $2,000.00 in taxable interest and $24,000.00 in capital gains, rents and your share of partnership distributions.

9) On November 28, 2017, NYSOH issued a notice that does not clearly state your eligibility that was effective January 1, 2018. However, in the "How We Made Our Decision" section, it states that you are no longer eligible for Medicaid because your household income of $26,000.00 was over the allowable income limit.

10) On December 1, 2017, NYSOH issued a notice stating that you were no longer eligible for Medicaid, however, your Medicaid coverage would continue until October 31, 2018. This notice was effective January 1, 2018.

11) You testified that you reside in Rockland County.

12) You testified that that you are appealing the eligibility determinations insofar as you should not have been determined eligible for Medicaid, that your Medicaid coverage was continued to October 31, 2018 and that you were not found eligible for the APTC so you could re-enroll in your gold-level qualified health plan.

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 Federal Register 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 November 1, 2017.

You are in a one-person household. According to the record, you expect to file your 2018 tax return as single and claim no dependents.

NYSOH determined your expected household income to be $2,379.00, after you submitted a copy of your 2016 tax return.

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 $2,379.00 is 19.73% of the 2017 FPL, NYSOH found you to be eligible for Medicaid on an expected annual income basis, using the information NYSOH calculated from your 2016 income tax return.

However, you testified the income listed on that November 20, 2017 application was not correct. You credibly testified that you are a [redacted] in [redacted]. You testified that you earn your income from your share of capital gains from sale of properties, distributions from partnerships and dividends from investments. You testified that the 2016 income tax return is not an accurate reflection of your expected income because your income can vary from year to year. You testified and your account reflects that you expect to receive $2,000.00 in taxable interest income and $24,000.00 in rental income, capital gains and related income from your share of real estate partnerships. Immediately after receiving the November 21, 2017 eligibility determination that stated you were

eligible for Medicaid you contacted NYSOH and advised them that they incorrectly changed your expected yearly income to $2,379.00.

Therefore, the credible evidence in the record is that at the time of the November 20, 2017 application, your expected yearly household income was $26,000.00. Since $26,000.00 is 215.59% of the 2017 FPL, it is greater than the allowable Medicaid limit, and the November 21, 2017 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 October 31, 2018.

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 November 21, 2017 eligibility determination 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 November 28, 2017 and December 1, 2017 eligibility determination notices are also RESCINDED.

Decision

The November 21, 2017, November 28, 2017 and December 1, 2017 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on one-person household, residing in Rockland County with an expected annual income of $26,000.00, as of January 1, 2018, and to notify you accordingly.

Effective Date of this Decision: March 20, 2018

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 one-person household, residing in Rockland County with an expected annual income of $26,000.00. You will receive an eligibility determination notice informing you of your new eligibility.

You will have the option of beginning your new coverage as of January 1, 2018, or to have it begin from this point forward.

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 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 November 21, 2017, November 28, 2017 and December 1, 2017 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on one-person household, residing in Rockland County with an expected annual income of $26,000.00, as of January 1, 2018, and to notify you accordingly.

You were incorrectly found eligible for Medicaid.

You will have the option of beginning your new coverage as of January 1, 2018, or to have it begin from this point forward; you may owe back premiums

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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).

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)

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।

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).

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 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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