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

Notice of Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025521

[redacted]

Dear [redacted],

On February 21, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 4, 2017 and December 8, 2017 eligibility determination 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 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).

This page intentionally left blank.

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

Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025521

[redacted]

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, 2017?
>
> 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, 2018?

Procedural History

On December 4, 2017, NY State of Health (NYSOH) issued an eligibility determination notice, based on your December 3 application, stating that you were eligible for Medicaid because your household income of $10,960.00 was at or below the allowable income limit. This eligibility was effective as of October 1, 2017.

On December 7, 2017, NYSOH received your updated application for health insurance; specifically, your income information was updated.

That same day, a preliminary eligibility determination was prepared 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 12 continuous months from the date that they were determined eligible. This eligibility was effective as of January 1, 2018.

Also on December 7, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your Medicaid coverage was continued and you were not found eligible for another insurance affordability program.

On December 8, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until September 30, 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 January 1, 2018.

On February 21, 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 2017 federal income tax return as single and claim no dependents.

2) According to the December 3, 2017 application, your expected annual household income is listed as $10,960.00. You testified that this income was not an accurate representation of your household income.

3) You testified that, at the time of your December 3, 2017 application, you believe a NYSOH representative incorrectly validated your income documentation in the form of your 2016 Individual Tax Return and submitted an application on your behalf (*see* Document [redacted]).

4) According to your NYSOH account, NYSOH calculated your income to be $10,960.00 by multiplying $2,080.00 in monthly income times 12 months, then subtracting $14,000.00 in deductions. ($2,080.00 x 12 = $24,960.00 – $14,000.00 = $10,906.00)

5) You testified that, as soon as you realized that the income on your application was incorrect, you contacted NYSOH on December 7, 2017.

6) According to the December 7, 2017 application, you attested to an increased expected household income of $24,960.00, based on a

monthly income of $2,080.00. You testified you are expecting a monthly income of closer to $2,700.00 per month.

7) You provided documentation showing your 2016 adjusted gross income was $49,375.00.

8) You testified that you reside in Suffolk County, NY.

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)).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, deductions that are attributable to a trade or business may be deductions from a taxpayer's adjusted gross income (26 USC § 62 (a)(1)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for Medicaid, effective October 1, 2017.

You are in a one-person household for purposes of this analysis. This is because your NYSOH application reflects that you expect to file your 2017 tax return as single and claim no dependents.

On December 3, 2017, NYSOH submitted an application stating you had an expected household income of $10,960.00. This amount was calculated by NYSOH as follows: By multiplying $2,080.00 in monthly income times 12 months, then subtracting $14,000.00 in deductions. ($2,080.00 x 12 = $24,960.00 – $14,000.00 = $10,906.00)

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 $12,060.00 for a one-person household. Since $10,960.00is 90.888% of the 2017 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 your 2016 tax return was not correctly verified and no longer

represented your current income situation. You further testified that when you realized the mistake, you attempted to correct your application on December 7, 2017. In fact, the record demonstrates that an incorrect gross income was used and applying a $14,000.00 deduction was incorrect, which resulted in your income being calculated by NYSIOH to be below the Medicaid limit.

Your 2016 tax return states your adjusted gross income after applicable self-employment deductions was $49,375.00 (*see* Document [redacted]. You testified that you expected your 2017 income to be less at approximately $2,700.00 per month, which equals $32,400.00 per annum.

Therefore, your household income at the time of the December 3, 2017 application was $32,400.00. Since $32,400.00 is 268.66% of the applicable 2017 FPL of $12,060.00, it is greater than the allowable Medicaid limit. Therefore, the December 4, 2017 eligibility determination notice finding you eligible for Medicaid as of October 1, 2017, was based on inaccurate income information and is not supported by the record.

The second issue under review is whether NYSOH properly determined that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until September 30, 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 December 8, 2017 eligibility determination notice was issued based on incorrect Medicaid eligibly finding 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 December 8, 2017 eligibility determination notice also is not supported by the record.

Now that there is a more accurate representation of your expected annual household income in 2018, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance going forward using a one-person household with an annual expected income of $32,400.00, for an individual residing in Suffolk County.

Decision

The December 4, 2017 eligibility determination notice was based on inaccurate income information and, therefore, is not supported by the record.

The December 8, 2017 eligibility determination notice was issued based on incorrect Medicaid eligibly finding 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.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance going forward using a one-person household with an annual expected income of $32,400.00, for an individual residing in Suffolk County.

Effective Date of this Decision: March 14, 2018

How this Decision Affects Your Eligibility

You were incorrectly found eligible for Medicaid and Medicaid continuous coverage.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based on the information presented during the hearing. In the interest of justice, this redetermination will be prospective so as not to disrupt your health insurance coverage as of October 1, 2017. 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 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 December 4, 2017 eligibility determination notice was based on inaccurate income information and, therefore, is not supported by the record.

The December 8, 2017 eligibility determination notice was issued based on incorrect Medicaid eligibly finding 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.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance going forward using a one-person household with an annual expected income of $32,400.00, for an individual residing in Suffolk County.

You were incorrectly found eligible for Medicaid and Medicaid continuous coverage.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based on the information presented during the hearing. In the interest of justice, this redetermination will be prospective so as not to disrupt your health insurance coverage as of October 1, 2017. 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:

[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.

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).