STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: March 22, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026929

Dear [redacted],

On March 5, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 4, 2018, February 22, 2018 and February 23, 2018 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
  PO 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(b).

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 22, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000026929

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 and your spouse were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until September 30, 2018?
>
> Did NYSOH properly determine that you and your spouse were conditionally eligible for Medicaid as of your February 21, 2018 and February 22, 2018 applications?

Procedural History

On September 1, 2017, NYSOH issued a notice of eligibility determination notice stating that you and your spouse were eligible for Medicaid because your household income of $226.71 was at or below the allowable income limit. This eligibility was effective as of October 1, 2017.

On October 12, 2017, NYSOH issued an enrollment notice confirming your auto-enrollment in a Medicaid Managed Care (MMC) plan as of October 11, 2017, with such coverage beginning November 1, 2017.

Between December 5, 2017 and December 20, 2017, NYSOH received several documents from you, including: (1) a partial tax return for 2016, and (2) a combined IRA retirement account portfolio.

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Also between December 5, 2017 and December 20, 2017, NYSOH received several updates to your application reflecting a net income of $0.00, after considering several deductions claiming within your application. In response to each of these applications you and your spouse were found conditionally eligible for Medicaid, pending receipt of additional income documentation to confirm your eligibility. However, each of the eligibility determination issued because of these applications did not clearly state your eligibility, and did not provide a deadline by which such income documentation was required to be received by NYSOH.

On January 3, 2018, NYSOH redetermined your eligibility for financial assistance with health insurance.

On January 4, 2018, NYSOH issued a notice of eligibility determination stating that you and your spouse 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 January 8, 2018, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were found no longer eligible for Medicaid, but would remain in that program until September 30, 2018.

Between February 21, 2018 and February 22, 2018, NYSOH received copies of (1) your 2017 tax return, ad (2) a rollover IRA account statement.

On February 21, 2018, NYSOH received an update to your application for financial assistance with health insurance.

On February 22, 2018, NYSOH issued an eligibility determination notice stating that you and your spouse were conditionally eligible for Medicaid, effective February 1, 2018. You were requested to provide additional income documentation by March 8, 2018 to confirm the eligibility of you and your spouse.

On February 22, 2018, NYSOH received an update to your application for financial assistance with health insurance.

On February 23, 2018, NYSOH issued an eligibility determination notice stating that you and your spouse were conditionally eligible for Medicaid, effective February 1, 2018. You were requested to provide additional income documentation by March 8, 2018 to confirm the eligibility of you and your spouse.

On March 5, 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 support the following findings of fact:

1) You and your spouse were found eligible for Medicaid, without condition, effective October 1, 2017.

2) Based on updates to your NYSOH application between December 5, 2017 and December 20, 2017, you were placed in a pending status to determine your eligibility for Medicaid.

3) On January 3, 2018, NYSOH redetermined your eligibility for financial assistance with health insurance.

4) On January 4, 2018, NYSOH issued an eligibility determination notice stating that you and your spouse were no longer eligible for Medicaid, but would remain in that program until at least September 30, 2018.

5) You testified that you originally appealed the January 4, 2018 eligibility determination notice since you did not understand why you and your spouse were not found eligible for Medicaid, but placed into Medicaid continuous coverage until September 30, 2018. You clarified during the hearing that you wanted you and your spouse to remain Medicaid eligible, but just wanted the findings explained to you.

6) You updated your account on February 21, 2018 and February 22, 2018 to reflect that your income had increased.

7) On February 22, 2018 and February 23, 2018, NYSOH issued eligibility determination notices stating that you and your spouse were found conditionally eligible for Medicaid, effective February 1, 2018.

8) You testified during the hearing that you were also seeking a review of the February 22, 2018 and February 23, 2018 eligibility determination notices insofar as you and your spouse's eligibility for Medicaid was only conditional.

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 can be provided through NYSOH 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 $16,240.00 for a two-person household (82 Federal Register 8831).

Generally, 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, citizenship status, 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 and your spouse were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until September 30, 2018.

Your NYSOH account reflects that you and your spouse were found eligible for Medicaid, without condition, effective October 1, 2017. This eligibility determination had not been appealed, and therefore is not under our review.

You testified that at the time of your January 3, 2018 redetermination, you provided documentation reflecting that you had received additional income from

you and your spouse's IRA. This update increased your annual household income above the Medicaid limit.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called "continuous coverage."

Credible evidence confirms that you and your spouse were eligible for Medicaid effective October 1, 2017, and that even though your estimated annual income increased when you provided additional income documentation to NYSOH, which caused a redetermination of you and your spouse's eligibility, you and your spouse remain enrolled in Medicaid for the remainder of your 12-month eligibility period. Therefore, the January 4, 2018 eligibility determination notice is correct and is AFFIRMED.

The second issue under review is whether NYSOH properly determined that you and your spouse were conditionally eligible for Medicaid as of your February 21, 2018 and February 22, 2018 applications.

Your account reflects that you provided additional income documentation to NYSOH on February 21, 2018 and February 22, 2018. However, for the reasons stated above, this should not have changed the eligibility of you and your spouse from receiving Medicaid through continuous coverage guidelines, to conditionally eligibility for Medicaid, effective February 1, 2018, from which you and your spouse could be disenrolled if NYSOH did not receive the requisite income documentation by the March 8, 2018 deadline referenced within the February 22, 2018 and February 23, 2018 eligibility determination notices.

Accordingly, the February 22, 2018 and February 23, 2018 eligibility determination notices are no longer supported by the record, and are RESCINDED.

Decision

The January 4, 2018 eligibility determination notice is AFFIRMED.

The February 22, 2018 and February 23, 2018 eligibility determination notices are RESCINDED.

Effective Date of this Decision: March 22, 2018

How this Decision Affects Your Eligibility

You and your spouse are eligible for Medicaid through continuous coverage until at least September 30, 2018, provided that you do not meet any exceptions allowing for disenrollment of you your spouse.

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 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).

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
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The January 4, 2018 eligibility determination notice is AFFIRMED.

The February 22, 2018 and February 23, 2018 eligibility determination notices are RESCINDED.

You and your spouse are eligible for Medicaid through continuous coverage until at least September 30, 2018, provided that you do not meet any exceptions allowing for disenrollment of you your spouse.

Legal Authority

We are issuing this determination in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

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 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 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.

(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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