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

Notice of Decision

Decision Date: March 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026992

[redacted]

Dear [redacted],

On March 6, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's August 1, 2017 renewal notice, which contains an eligibility determination, and January 9, 2018 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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DEPARTMENT OF HEALTH
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Albany, NY 12211

Decision

Decision Date: March 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026992

[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 your family was eligible for Medicaid effective October 1, 2017?
>
> Did NY State of Health properly determine that your family was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until September 30, 2018?

Procedural History

On August 2, 2017, NY State of Health (NYSOH) issued a renewal notice, which contained an eligibility determination stating that it was time to renew your and your family's health insurance for the upcoming health insurance year. This notice further indicated that NYSOH determined that, based on information from federal and state data sources, you and your family were qualified for Medicaid through NYSOH, effective October 1, 2017.

On August 17, 2017, NYSOH issued a plan disenrollment notice stating that your and your spouse's Essential Plan coverage and your children's Child Health Plus plan coverage would end on September 30, 2017.

On September 16, 2017, NYSOH issued a plan enrollment notice confirming your and your family's enrollment in Medicaid Managed Care plans, effective October 1, 2017.

On January 9, 2018, NYSOH received your updated application for financial assistance with health insurance. That day, a preliminary eligibility determination was prepared stating that you and your family were no longer eligible for Medicaid, but that NYSOH will continue your and your family's Medicaid coverage until September 30, 2018.

Also on January 9, 2018, you spoke to NYSOH's Account Review Unit and appealed the preliminary eligibility determination insofar as you and your family were still eligible for Medicaid.

On January 10, 2018, NYSOH issued an eligibility determination notice, based on your January 9, 2018 application, stating that you and your family were no longer eligible for Medicaid, but that NYSOH will continue your and your family's Medicaid coverage until September 30, 2018. This eligibility was effective January 1, 2018.

Also on January 10, 2018, NYSOH issued a plan enrollment notice confirming that you and your family were enrolled in Medicaid Managed Care plans, effective October 1, 2017.

On March 6, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open until March 22, 2018, to allow you time to submit supporting income documentation.

On March 6, 2018, you uploaded the supporting documentation to your NYSOH account. The documents were made part of the record as "Appellant's Exhibit #1" and the record was closed.

Findings of Fact

A review of the record supports the following findings of fact:

1) According to your NYSOH account, you and your family were found eligible for Medicaid, based on state and federal data sources, effective October 1, 2017.

2) The eligibility determination notice that was issued on August 2, 2017 indicated that state and federal data sources showed that your annual household income was between $0.00 and $44,322.00, and the eligibility determination relied upon this information. You testfied that this amount was incorrect.

3) According to your NYSOH account and at all times relevant, your children were between the ages of one and nineteen years old.

4) According to your NYSOH account and your Exhibit #1, you filed your 2017 federal tax return with a tax filing status of married filing jointly and you claimed three dependents on that tax return.

5) Your 2017 federal tax return, that you uploaded to your NYSOH account on March 6, 2018, indicates that your annual household income for 2017 was $58,395.00 (*see* Appellant's Exhibit #1).

6) You testfied that you contacted NYSOH on September 15, 2017, to determine whether you and your family were properly found eligible for Medicaid and you were informed that there was nothing you could do to change your and your family's eligibility at that point.

7) You testfied that you were informed that the NYSOH representative was unable to submit a new application.

8) You testified that you were further informed that you would need to call back when your spouse determined his permanent placement after graduating from [redacted] and knew what his new income would be.

9) You testfied that you were informed by the NYSOH representative that at that point your health insurance coverage would go back to what you and your family had last year, if your income remained the same.

10) You testfied that you contacted NYSOH in January 2018, after you spouse graduated from [redacted] and obtained his permanent employment.

11) You testfied that your income for 2018 will be about the same as it was in 2017.

12) You testfied that you expect to file your 2018 federal income tax return as married filing jointly, and you expect to claim three dependents on that tax return.

13) According to the January 9, 2018 application, you attested to an expected annual household income for 2018 of $52,000.00.

14) You testfied that you would like you and your spouse to be found eligible for the Essential Plan, and your children to be found eligible for Child Health Plus because Medicaid does not cover your child's necessary medical supplies.

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 $28,780.00 for a five-person household (82 Federal Register 8831).

Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1).

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 $28,780.00 for a five-person household (82 Fed. Reg. 8831).

Medicaid Continuous Coverage

Most applicants 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 and your family were eligible for Medicaid effective October 1, 2017.

You and your family are in a five-person household for purposes of this analysis. This is because, according to the record, you filed your 2017 tax return as married filing jointly and claimed your three children as dependents.

The system ran an application on your and your family’s behalf on August 1, 2017, and based on federal and state data sources, determined that your expected annual household income was between $0.00 and $44,322.00, and the eligibility determination relied upon this information.

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. Medicaid can also be provided through NYSOH to children between the ages of one but younger than nineteen who meet the non-financial requirements and have a household MAGI that is at or below 154% of the FPL for the applicable family size.

On the date of your application, the relevant FPL was $28,780.00 for a five-person household. The range of income stated in the August 2, 2017 notice does not clearly identify the household income obtained by NYSOH. For you and your spouse to be eligible for Medicaid, your household income had to be at or below $39,717.00. As to your children, an annual household income of up to $44,322.00 is at 154% of the 2017 FPL for a five-person household. Assuming the income information from federal and state data sources was at or below $39,717.00, it was proper for NYSOH to find you and your family eligible for Medicaid on an expected annual income basis, using the information obtained from federal and state data sources.

However, you testified the income listed on that application that was obtained from federal and state data sources was not correct. You further testified that you attempted to determine if you and your family were properly found eligible for Medicaid in September 2017. However, you testfied that you were informed by the NYSOH representative that there was nothing you could do until you knew what your spouse's new income amount would be after graduating from [redacted]. But that at that point, your and your family's eligibility would go back to what you had last year if your income remained the same.

On March 6, 2018, you provided your 2017 income tax return which indicates that your household's annual income for the year 2017 was $58,395.00 (*see* Appellant's Exhibit #1).

Therefore, it is reasonable to conclude that the information NYSOH obtained from federal and state data sources was erroneous through no fault of your own. The record indicates that your expected annual household income at the time of the August 1, 2017 application was $58,395.00. Since $58,395.00 is 202.90% of the 2017 FPL, it is greater than the allowable income limit for Medicaid for both adults and children between the ages of one and nineteen.

As a result, the August 2, 2017 renewal notice, which contains an eligibility determination finding you and your family eligible for Medicaid is not supported by the record such that your family's eligibility for financial assistance will need to be redetermined.

The second issue under review is whether NYSOH properly determined that you and your family were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until September 30, 2018.

Once a person(s) 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." However, when the Medicaid finding is based on incorrect information, it cannot be sustained.

Since the August 2, 2017 eligibility determination was issued based on incorrect information and is not supported by the record through no fault of your own, and there was no other determination finding you and your family eligible for Medicaid, the continuous coverage policy should not have been applied to you and your family. Therefore, the January 10, 2018 eligibility determination notice also is not supported by the record such that your family's eligibility for financial assistance will need to be redetermined.

Your case is RETURNED to NYSOH to redetermine your and your family's eligibility, as of the date of this Decision, based on a five-person household, for a family residing in Onondaga County with an expected annual income for 2018 of $58,395.00, and to notify you accordingly.

Decision

The August 2, 2017 renewal notice, which contains an eligibility determination finding you and your family eligible for Medicaid is not supported by the record such that your family's eligibility for financial assistance will need to be redetermined.

Similarly, the January 10, 2018 eligibility determination notice is not supported by the record such that your family's eligibility for financial assistance will need to be redetermined.

Your case is RETURNED to NYSOH to redetermine your and your family's eligibility, as of the date of this Decision, based on a five-person household, for a family residing in Onondaga County with an expected annual income for 2018 of $58,395.00, and to notify you accordingly.

Effective Date of this Decision: March 13, 2018

How this Decision Affects Your Eligibility

You and your family were incorrectly found eligible for Medicaid through no fault of your own.

This is not a final determination of your and your family's eligibility going forward.

Your case is being sent back to NYSOH to redetermine your family's eligibility for financial assistance based on the information presented during the hearing. NYSOH will notify you once this has been completed.

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 August 2, 2017 renewal notice, which contains an eligibility determination finding you and your family eligible for Medicaid is not supported by the record such that your family's eligibility for financial assistance will need to be redetermined.

Similarly, the January 10, 2018 eligibility determination notice is not supported by the record such that your family's eligibility for financial assistance will need to be redetermined.

Your case is RETURNED to NYSOH to redetermine your and your family's eligibility, as of the date of this Decision, based on a five-person household, for a family residing in Onondaga County with an expected annual income for 2018 of $58,395.00, and to notify you accordingly.

You and your family were incorrectly found eligible for Medicaid through no fault of your own.

This is not a final determination of your and your family's eligibility going forward.

Your case is being sent back to NYSOH to redetermine your family's eligibility for financial assistance based on the information presented during the hearing. NYSOH will notify you once this has been completed.

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 तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई 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).