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

# Notice of Decision

Decision Date: May 3, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027910

[redacted]

Dear [redacted]

On April 25, 2018 you appeared by telephone at a hearing on your appeal of NY State of Health's January 7, 2018 and January 27, 2018 eligibility redetermination 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).

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DEPARTMENT OF HEALTH
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# Decision

Decision Date: May 3, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027910

[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 January 1, 2018?
>
> Did NY State of Health properly determine that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until December 31, 2018?

## Procedural History

On January 6, 2018, you contacted NY State of Health (NYSOH) by phone to submit an updated application for financial assistance with health insurance.

On January 7, 2018, NYSOH issued an eligibility redetermination notice, based on the January 6, 2018 application, stating that you were eligible for Medicaid because your household income of $20,700.00 was at or below the allowable income limit. This eligibility was effective as of January 1, 2018. The notice further stated that you no longer qualified for the Essential Plan as of December 31, 2018.

Also on January 7, 2018, NYSOH issued a disenrollment notice, stating that your Essential Plan coverage would end on January 31, 2018 because you were no longer eligible.

On January 13, 2018, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan as of February 1, 2018.

On January 27, 2018, you contacted NYSOH by phone to submit an updated application for financial assistance with health insurance; specifically, the income information was updated. That day a preliminary eligibility determination was prepared, stating that, although you no longer qualified for Medicaid, NYSOH would continue your Medicaid coverage.

Also on January 27, 2018, you contacted NYSOH's Account Review Unit and appealed insofar as you were found eligible for Medicaid and you were not able to enroll in the Essential Plan.

On January 28, 2018, NYSOH issued an eligibility redetermination notice, based on the January 27, 2018 application, stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until December 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 February 1, 2018.

On February 14, 2018, NYSOH issued an eligibility redetermination notice, stating that you were eligible for the Essential Plan, effective February 1, 2018, because you had been granted Aid to Continue until a decision is made on your appeal.

Also on February 14, 2018, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in an Essential Plan with a start date of February 1, 2018.

On March 29, 2018, you were scheduled for a telephone hearing with a Hearing Officer from NYSOH's Appeal Unit. You requested that day that the hearing be adjourned to a later date.

On April 25, 2018, you had an adjourned telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you gave permission to the Hearing Officer to listen to your recorded phone calls with NYSOH. 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 married filing jointly and claim no dependents.

2) You testified, and the record reflects, that you are the sole person in your household seeking insurance through NYSOH.

3) You testified, and the record reflects, that you receive $825.00 per month in Social Security benefit payments and your husband receives $900.00 per month in Social Security benefit payments.

4) On January 6, 2018, you contacted NYSOH by phone to submit an updated application for financial assistance with health insurance. A review of your phone conversation with the NYSOH representative indicates that, when it came time to enter your expected income for 2018, you stated that you were unable to estimate the amount because you were not currently employed and did not know when you would be employed again. You hoped to have a job sometime in the future. You agreed to have your earned income entered as zero. As a result of the updated income, you were determined eligible for Medicaid, which you immediately indicated that you did not want.

5) Your January 6, 2018 application indicated an expected household income of $20,700.00 consisting solely of Social Security benefit payments that you ($825.00 per month) and your husband ($900.00 per month) both receive.

6) On January 27, 2018 you contacted NYSOH by phone to submit an updated application for financial assistance with health insurance. A review of the phone call indicates that you were starting a new job and you wanted to update the income on your application.

7) Your January 27, 2018 application indicated an expected household income of $25,900.00 consisting of the same amount of Social Security payments for you and your husband as the January 6, 2018 application, but with an additional $5,200.00 from your new job.

8) You testified that your household income for January of 2018 was $1,725.00, consisting solely of your and your husband's Social Security benefit payments.

9) You testified that your employment was "stop and go" and, as such, your income varied from month to month.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

## Applicable Law and Regulations

Medicaid

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 FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

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 January 2, 2018 application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

On the date of your January 27, 2018 application, that was the 2018 FPL, which is $16,460.00 for a two-person household (83 Fed. Reg. 2642).

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).

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 January 1, 2018.

You are in a two-person household. You expect to file your 2018 income tax return as married filing jointly and will not claim dependents on that tax return.

On your January 7, 2018 application, you attested to an expected household income of $20,700.00. A review of the phone call you had with the NYSOH representative indicates that, at the time of the call, you were not employed and did not know when you would be employed again. You also indicated that you could not estimate what your income from future employment would be. You agreed to report your anticipated earned income as $0.00. Since you were not employed, did not know when you would be employed again, could not estimate income from a job, and agreed to report $0.00 as your anticipated income, the record reflects that the reported income of $20,700.00 was the most accurate reflection of your anticipated income that you could provide at the time. NYSOH relied on this amount in making its eligibility determination.

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 January 6, 2018 application, the relevant FPL was $16,240.00 for a two-person household. Since $20,700.00 is 127.46% 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.

Furthermore, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. You testified that your household income for January 2018 was $1,725.00, consisting solely of your and your husband’s Social Security benefit payments.

To be eligible for Medicaid based on monthly income, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,868.00 per month. Since you testified that you had a household income of $1,725.00 in January 2018, even if your reported annual income was discounted, you would still qualify for Medicaid based on your monthly income for January 2018.

Since the January 8, 2018 eligibility redetermination properly stated that, based on the information you provided, you were eligible for Medicaid, it is correct and is AFFIRMED.

The second issue is whether NYSOH properly determined that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until December 31, 2018.

On January 27, 2018, you updated your application to include the earned income you will be receiving from a new job. This update increased your annual household income to $25,900.00, which is 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 were eligible for Medicaid effective January 1, 2018 and that even though your estimated annual income increased when you updated your application on January 27, 2018, your eligibility for Medicaid continues for the remainder of your 12-month eligibility period. Therefore, the January 27, 2018 eligibility redetermination is correct and is AFFIRMED.

## Decision

The January 7, 2018 and January 27, 2018 eligibility redetermination notices are AFFIRMED.

## Effective Date of this Decision: May 3, 2018

## How this Decision Affects Your Eligibility

You were properly determined eligible for Medicaid effective January 1, 2018.

Your Medicaid eligibility continues for 12-months, until December 31, 2018, barring subsequent changes in your 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 January 7, 2018 and January 27, 2018 eligibility redetermination notices are AFFIRMED.

You were properly determined eligible for Medicaid effective January 1, 2018.

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).

Your Medicaid eligibility continues for 12-months, until December 31, 2018, barring subsequent changes in your eligibility.

## Legal Authority

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

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## A Copy of this Decision Has Been Provided To:

[redacted]

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## 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।

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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 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.

**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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