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

Notice of Decision

Decision Date: April 25, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000028527

[redacted]

[redacted]

On April 16, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 21, 2017 and February 7, 2018 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: April 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028527

[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 October 21, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of $16,000.00 was at or below the allowable income limit. This eligibility was effective as of October 1, 2017.

On October 31, 2017, NYSOH issued a notice of enrollment confirming your enrollment in a Medicaid Managed Care plan, effective December 1, 2017.

On February 6, 2018, NYSOH received your updated application for health insurance; specifically, the 2018 expected annual household income information attested to was updated from $16,000.00 to $25,000.00.

On February 7, 2018, NYSOH issued a notice of eligibility determination 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 February 1, 2018.

Also on February 7, 2018, 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 a qualified health plan.

On April 16, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You uploaded a copy of your 2016 income tax return [redacted], October 2017 monthly [redacted] statement [redacted] February 2018 [redacted] statement [redacted], and your January - April 2018 [redacted] Financial statement [redacted]) at the time of the hearing. The record was developed and the hearing was closed that same day.

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 claim no dependents.

2) According to the October 20, 2017 application, you attested to an expected annual household income of $16,000.00. You testified that this amount was not an accurate representation of your expected household income.

3) You testified that at the time of your October 20, 2017 application you had filed your 2014, 2015 and 2016 income tax returns at the same time. You mistakenly put a previous year's income on the application, which was $16,000.00.

4) You testified that you were unaware you were enrolled in Medicaid until your plan returned your check stating that you had overpaid your premium.

5) You testified that once you realized that the you were found eligible for Medicaid you contacted your application counselor to advise them of the error and then contacted NYSOH to update your account.

6) According to the February 6, 2018 application, you attested to an increased expected household income of $25,000.00. However, you testified that you expect your annual income to increase to approximately $30,000.00.

7) You testified that you own your own business and do [redacted] work; therefore, your monthly income varies.

8) You testified that your income for the month of October 2017 was $2,138.03, consisting of $1,838.03 you earned from your business and $300.00 you earned from [redacted] work.

9) You testified that your income for the month of February 2018 was $12,774.99, consisting of $12,474.99 you earned from your business and $300.00 you earn every month from [redacted] work.

10) You uploaded your monthly [redacted] statement for October 2017 showing a total amount received of $1,838.03.

11) You uploaded your monthly [redacted] statement for February 2018 showing a total amount received of $12,474.99.

12) Your application indicates that you reside in [redacted].

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 Fed. Reg. 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 October 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.

On your October 20, 2017 application, you attested to an expected household income of $16,000.00.

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 $16,000.00 is 132.67% 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 you mistakenly listed a previous year’s income on the application. You further testified that you were unaware you were enrolled in Medicaid until your plan returned your check stating that you had overpaid your premium. Once you realized that the you were found eligible for Medicaid you contacted the application counselor and updated your NYSOH account.

You provided documentation that shows that your income for October 2017 was at least $1,838.03 that you earned from your business (Document [redacted].

Therefore, your 2017 annual household income at the time of your October 20, 2017 application was at least $23,894.39 and your monthly income in October 2017 was at least $1,838.03.

On the date of your October 20, 2017 application, 138% of the FPL for a one-person household seeking Medicaid was $16,643.00 on an annual basis and $1,378.00 on a monthly basis. Since an annual income of at least $23,894.39 is 198.13% of the 2017 FPL for a one-person household, it is greater than the allowable Medicaid limit, and the monthly income of at least $1,838.03 is more than the maximum allowable monthly Medicaid limit, the October 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 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 October 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 February 7, 2018 eligibility determination notice stating that you will continue to receive Medicaid until September 30, 2018 is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household, residing in Queens County with an expected annual income of $30,000.00.

Decision

The October 21, 2017 and February 7, 2018 eligibility determination notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household, residing in Queens County with an expected annual income of $30,000.00.

Effective Date of this Decision: April 25, 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 the information presented during the hearing. 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 October 21, 2017 and February 7, 2018 eligibility determination notices are RESCINDED.

You were incorrectly found eligible for Medicaid.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household, residing in Queens County with an expected annual income of $30,000.00.

Legal Authority

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

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 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).