



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

Notice of Decision

Decision Date: May 1, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000029214



Dear [REDACTED]

On April 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 28, 2017 eligibility determination notice and February 23, 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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Decision

Decision Date: May 1, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000029214



Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Was your appeal of the October 28, 2017 renewal notice timely?

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 October 7, 2017, New York State of Health (NYSOH) redetermined your eligibility for financial assistance with your health insurance from state and federal data sources.

On October 28, 2017, NYSOH issued a renewal notice stating there was no action required for your 2018 renewal. The notice stating you qualify for Medicaid, effective January 1, 2018. The notice stated this was because federal and state data sources show your income was between \$0.00 and \$22,412.00. The notice stated if you want to make a change, you must do so between November 16, 2017 and December 15, 2017.

On November 17, 2017, NYSOH issued a plan enrollment notice stating you were enrolled in a Medicaid Managed Care plan, effective January 1, 2018. The

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notice stated you were enrolled in a health plan with the same insurance company you had before. The notice stated if you would like to choose a different insurance company or enroll in a different health plan, you may do so at any time.

On February 22, 2018, NYSOH received your updated application for health insurance, in which the income information was updated to \$29,007.00.

That day, a preliminary eligibility determination was made stating 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.

Also on February 22, 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 another insurance affordability program.

On February 23, 2018, NYSOH issued a notice of eligibility determination 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 23, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective January 1, 2018.

On April 12, 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 and 2018 federal income tax returns as married filing jointly, and claim no dependents.
- 2) According to the October 28, 2017 renewal notice you qualified for Medicaid because federal and state data sources show your income was between \$0.00 and \$22,412.00. You testified this amount was not an accurate reflection of your household income.

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- 3) You testified you only received a notice that you were signed up for your health plan for another year and were not aware you were determined eligible for Medicaid.
- 4) You testified you became concerned that you were not receiving a bill from your Essential Plan with your same provider in February 2018, and you realized when you contacted NYSOH that you were now eligible for and enrolled in Medicaid.
- 5) You testified that a NYSOH representative told you the October 28, 2017 renewal notice relied on income information that did not include your spouse's income from Social Security Disability as data sources did not pick up this amount as taxable income. You testified this was the first time you realized you were incorrectly determined eligible for Medicaid.
- 6) According to the February 22, 2018 application, you attested to an expected household income of \$29,007.00.
- 7) You testified your spouse receives a monthly amount of \$1,337.00 in Social Security Disability.
- 8) You testified your annual income is difficult to project as you own your personal business.
- 9) For your 2017 tax return you had an adjusted gross income of \$14,587.00. Your application submitted on February 22, 2018 projected an income of \$12,963.00.
- 10) You testified you were not sure if this amount would be the correct amount for 2018 and that you usually base your projections on last year's tax return.
- 11) Your application states you reside in [REDACTED], NY.

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

Applicable Law and Regulations

Timely Appeal Requests

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

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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)).

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 October 2017 application, that was the 2017 FPL, which is \$16,240.00 for a two -person household (82 Federal Register 8831).

On the date of your February 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).

Medicaid Continuous Coverage

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)).

In the following additional situations, individuals are not entitled to receive continuous coverage:

- Unable to locate;
- Death;
- Consumer requests to have his/her Medicaid closed;

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- Failure to provide or cooperate in obtaining a Social Security Number, if otherwise required;
- Failure to provide documentation of citizenship after the reasonable opportunity period;
- Moved out of State;
- Coverage established under MAGI in error;
- Undocumented pregnant women (only get 60 days post-partum);
- Failure to comply with absent parent (IV-D) requirements; and
- Individuals receiving treatment in a setting where Medicaid eligibility is not available

(N.Y. Soc. Serv. Law § 366(4)(c); GIS 15 MA/22).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income (MAGI) 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)).

Legal Analysis

The first issue under review is whether you provided a timely appeal of the October 28, 2017 renewal notice.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your eligibility for Medicaid as determined in the October 28, 2017 renewal notice an appeal should have been filed by December 27, 2017. According to the credible evidence in the record, you did not contact NYSOH until February 22, 2018 to file a formal complaint and a formal appeal was not filed until that date.

However, you testified you only received a notice that you were signed up for your health plan for another year and were not aware you were determined eligible for Medicaid. You testified you became concerned that you were not receiving a bill from your Essential Plan with your same provider in February 2018, and only realized when you contacted NYSOH that you were now eligible for and enrolled in Medicaid. You were told by a NYSOH representative that the amount of income the October 28, 2017 renewal notice relied on did not include your spouse's income from Social Security Disability as data sources did not pick

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up this amount as taxable income. You testified this was the first time you realized you were incorrectly determined eligible for Medicaid.

Since you were only first made aware of the incorrect information and data relied upon by NYSOH in making your determination for Medicaid in February 2018, NYSOH's Appeals Unit may consider your appeal of the October 28, 2017 renewal notice as timely.

The second 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 for purposes of this analysis. This is because, according to the record, you expect to file your 2017 and 2018 federal income tax returns as married filing jointly, and claim no dependents.

A renewal notice was issued on October 28, 2017, stating your eligibility was redetermined for 2018 and you qualified for Medicaid as of January 1, 2018, because federal and state data sources show your income was between \$0.00 and \$22,412.00. The determination as based on state and federal data sources received on October 7, 2017. You testified this amount was not an accurate reflection of your household income.

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 October 7, 2017 determination from state and federal data sources, the relevant FPL was \$16,240.00 for a two-person household. NYSOH received information from data sources that your income was between \$0.00 and \$22,412.00. An income amount of \$22,412.00 or under would have correctly found you to be eligible for Medicaid on an expected annual income basis of 138% FPL.

However, you testified the income data that NYSOH based its determination on was not correct because it did not include your spouse's Social Security Disability benefits. NYSOH bases its determinations on MAGI income, which means adjusted gross income, increased by any income received by Social Security benefits. Your spouse's Social Security Disability benefits would therefore be counted as income.

According to the February 22, 2018 application, you attested to an expected household income of \$29,007.00. You testified you were not sure if this amount would be the correct amount for 2018 and that you usually base your projections on your last year's tax return. For your 2017 tax return you had an adjusted gross income of \$14,587.00. Your husband receives \$1,337.00 in Social Security Disability a month. Adding the annual income you received in 2017 of \$14,587.00 and your husband's annualized Social Security benefit of \$16,044.00 would be \$30,631.00.

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Since your application amount of \$29,007.00 is 178.61% of the 2017 FPL, it is greater than the allowable Medicaid limit, the October 28, 2017 eligibility determination notice finding you eligible for Medicaid is not supported by the record. Additionally, an income of \$30,631.00 would be 188.61% of 2017 FPL and would render the October 28, 2017 determination improper.

The third issue under review is whether NYSOH properly determined that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until December 31, 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.” An individual is not entitled to receive continuous coverage, however, if the persons coverage was determined under MAGI incorrectly.

Since the October 28, 2017 renewal notice was issued based on incorrect income information obtained by federal and state data sources and is not supported by the record, the continuous coverage policy should not have been applied to you. Therefore, the February 23, 2018, eligibility determination notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to redetermine your eligibility based on two-person household, for an individual residing in Niagara County with an expected annual income of \$30,631.00.

Decision

Your appeal of the October 28, 2017 renewal notice is timely.

The October 28, 2017 eligibility determination was based on inaccurate income information and, therefore, was improper.

The February 23, 2018, eligibility determination notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to redetermine your eligibility as of the date of this Decision, based on two-person household, for an individual residing in Niagara County with an expected annual income of \$30,631.00.

Effective Date of this Decision: May 1, 2018

How this Decision Affects Your Eligibility

You were incorrectly found eligible for Medicaid.

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 case is being sent back to NYSOH to redetermine your eligibility as of the date of this Decision, 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:

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).

- 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

Your appeal of the October 28, 2017 renewal notice is timely.

The October 28, 2017 eligibility determination was based on inaccurate income information and, therefore, was improper.

The February 23, 2018, eligibility determination notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to redetermine your eligibility as of the date of this Decision, based on two-person household, for an individual residing in Niagara County with an expected annual income of \$30,631.00.

You were incorrectly found eligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your eligibility as of the date of this Decision, based on the information presented during the hearing. 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:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. y&b&tumi ama wo obi a okyer& 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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