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

Notice of Decision

Decision Date: April 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029314

[redacted]

[redacted],

On April 17, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 1, 2018, March 15, 2018 and March 16, 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
  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: April 27, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000029314

[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 February 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 January 31, 2019?

Procedural History

On February 23, 2018, NYSOH received your updated application for financial assistance for health insurance.

That day, a preliminary determination was made stating that NYSOH was unable to confirm your eligibility for health insurance because the income information you entered your application did not match state and federal data sources.

Also on February 23, 2018, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you were not found eligible for advance premium tax credits and cost-sharing reductions.

On February 24, 2018, NYSOH issued a notice stating that more information was needed to make a determination as to your eligibility. The notice explained the income information you entered into your application did not match what was obtained from state and federal data sources. You were instructed to submit income documentation for your household by March 10, 2018.

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Also on February 24, 2018, NYSOH issued a disenrollment notice stating that your enrollment in your qualified health plan would end effective March 31, 2018.

On February 27, 2018, NYSOH received income documentation you submitted by fax.

On February 28, 2018, NYSOH reviewed the income documentation you submitted and determined it was sufficient to verify your household income. NYSOH recalculated your household income based on this information, updated the income in your application based on this recalculation, and then submitted an application on your behalf.

On March 1, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid because your household income of $7,220.00 was at or below the allowable income limit for that program. This eligibility was effective as of February 1, 2018.

On March 14, 2018 and March 15, 2018, NYSOH received your updated application for health insurance, in which the income information was updated.

As a result of these updated applications, on March 15, 2018 and March 16, 2018, NYSOH issued eligibility determination notices stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until January 21, 2019, 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 March 1, 2018.

On April 17, 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) On February 27, 2018, you faxed a copy of your Unemployment Insurance Monetary Benefit Determination to NYSOH, which states that beginning January 8, 2018, you began receiving $435.00 per week in unemployment benefits, which would end January 13, 2019 (*see* Document [redacted].

2) The February 28, 2018 application submitted by NYSOH on your behalf listed an annual income of $7,220.00. This amount consisted of income you receive from unemployment insurance benefits.

3) You testified that this amount was incorrect. You further testified that, as soon as you realized that the income on your application was incorrect, you contacted NYSOH and asked to receive advance premium tax credits and cost-sharing reductions.

4) You testified that you are currently receiving unemployment benefits in the amount of $435.00 per week, that you do not currently have any other source or income, but that you anticipate securing employment soon, and you believe your gross income for 2018 will be approximately $45,000.00.

5) According to the March 14, 2018 application, you attested to an increased expected household income of $44,220.00, which you testified is an amount you anticipate earning if you secure employment.

6) You expect to file your 2018 federal income tax return as single, and you will not claim any dependents on that tax return.

7) 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

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 2018 FPL, which is $12,140.00 for a one-person household (83 Federal Register 2642).

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)).

Unemployment Insurance Benefit Law

An eligible claimant shall be paid benefits for any week equal to his or her benefit rate multiplied by the percentage of reduction of his or her wages resulting from reduced hours of work, but only if such percentage is no less than twenty percent. The weekly benefit amount shall be rounded off to the nearest dollar. A claimant shall not be paid such benefits in excess of twenty-six weeks during a benefit year (NY CLS Labor § 607 (1)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for Medicaid effective February 1, 2018.

On February 28, 2018, NYSOH representative reviewed the income documentation you submitted and recalculated the household income based on that documentation. An application for financial assistance was submitted on your behalf by a NYSOH representative. The NYSOH representative entered an income of $7,220.00 into that application, and the eligibility determination relied on that information.

You are in a one-person household for purposes of this analysis. This is because you expect to file your 2018 tax return as single, and you will not claim any dependents on that tax return.

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 $12,140.00 for a one-person household. Since $7,220.00 is 59.47% of the 2018 FPL, NYSOH found you to be eligible for Medicaid on an expected annual income basis, using the income information as calculated by NYSOH and your household size as provided in your application.

However, you testified the income listed on that application was not correct, and that when you realized the mistake, you attempted to correct your application. You testified that you are currently not working, and that your only income is from weekly unemployment insurance benefits. You provided documentation that your weekly benefit rate is $435.00 per week, which began [redacted]. You further testified that you hope to secure employment soon, and that you expect to make approximately $45,000.00 in 2018.

Based on the evidence in the record, as of the date of your February 28, 2018 application, your expected annual income for 2018 is $11,310.00, which is the result of $435.00 per week you receive in unemployment insurance benefits for 26 weeks, the maximum amount permitted during a benefit year. Potential income you could earn should you secure employment may not be counted when making an income determination.

Since $11,310.00 is 93.16% of the 2018 FPL, you are still eligible for Medicaid on an expected annual income basis, and the February 28, 2018 eligibility determination notice 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 January 31, 2019.

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.”

Credible evidence confirms that you were eligible for Medicaid effective February 1, 2018, that you are currently unemployed and that your only income consists of $435.00 per week in unemployment insurance benefits, and that you remain enrolled in Medicaid for the remainder of your 12-month eligibility period.

Therefore, the March 15, 2018 eligibility determination notice and the March 16, 2018 eligibility determination notice are correct and are AFFIRMED.

Decision

The March 1, 2018 eligibility determination is AFFIRMED.

The March 15, 2018 eligibility determination notice is AFFIRMED.

The March 16, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: April 27, 2018

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on February 1, 2018, continues until January 21, 2019, 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 March 1, 2018 eligibility determination is AFFIRMED.

The March 15, 2018 eligibility determination notice is AFFIRMED.

The March 16, 2018 eligibility determination notice is AFFIRMED.

Your Medicaid coverage, which began on February 1, 2018, continues until January 21, 2019, barring subsequent changes in your 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:

[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 1-855-355-5777번으로 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 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.

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