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

Notice of Decision

Decision Date: June 28, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000006843

[redacted]

Dear [redacted],

On June 23, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's January 19, 2016 eligibility determination.

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 NY State of Health 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.

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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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Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On January 19, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost through NYSOH, effective March 1, 2016. The notice further stated that you were not eligible for Medicaid because your income was over the allowable income limit for that program.

On February 4, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the eligibility redetermination as it related to your Medicaid eligibility.

On June 23, 2016, 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 testified that you expect to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking health insurance for yourself.

3) You testified you are not seeking Advance Premium Tax Credits or Cost Sharing Reductions. You are seeking review of your Medicaid eligibility.

4) You testified that you presently receive health insurance coverage through your mother's health insurance plan and that you are looking for Medicaid to be the second payer.

5) The application that was submitted on January 18, 2016 listed annual household income of $30,461.00 that you earn from your employment. You testified that you work a 40 hour week at a pay rate of $16.20 per hour. You testified that your net pay is $927.00 every two weeks.

6) You testified that you have worked full time with your employer since January 2015. You will continue to work full time with this employer during 2016.

7) Your application states that you have deductions of $1000.00 per quarter for college tuition and fees. You also have $75.00 per month in student loan interest deductions. Your testimony confirmed these deductions.

8) Your application states that you live in Lewis County.

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)), N.Y. Soc. Serv. 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 application, that was the 2015 FPL, which is $11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

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).

Legal Analysis

The issue is whether NYSOH properly determined that you were ineligible for Medicaid.

The application that was submitted on January 18, 2016 listed an annual household income of $25,561.00, consisting of $30,461.00 you attested to income you receive from a job and $4,900.00 you expect to claim in deductions; the eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2016 income taxes as single and will claim no dependents on that tax return.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income (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 $11,770.00 for a one-person household. Since $25,561.00 is 217.17% of the 2015 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, 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 you receive net pay of $927.00 every two weeks. This would be a net pay of $1,854.00 per month.

To be eligible for Medicaid on a monthly basis, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,354.00 per month. Since you testified that your income was at least $1,854.00 in January 2016, you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the January 19, 2016 eligibility determination properly stated that, based on the information you provided, you were ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The January 19, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: June 28, 2016

How this Decision Affects Your Eligibility

You are ineligible for Medicaid.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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:

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- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

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  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The January 19, 2016 eligibility redetermination notice is AFFIRMED.

You are ineligible for Medicaid.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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