



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

Notice of Decision

Decision Date: February 10, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000011607



Dear [REDACTED],

On January 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 4, 2016 eligibility determination and disenrollment notices.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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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Issues

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

Did New York State of Health (NYSOH) properly determine that you were not eligible for Medicaid as of August 4, 2016?

Did NYSOH properly disenroll you from your Medicaid coverage effective August 31, 2016?

Procedural History

On September 3, 2015, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective as of September 1, 2015.

Also on September 3, 2015, NYSOH issued an enrollment notice confirming that as of September 2, 2015, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of October 1, 2015.

On July 3, 2016, NYSOH issued a renewal notice stating that you could not enroll in your current health plan for the next coverage year. The notice stated, in relevant part, that you were no longer eligible for financial assistance because federal and state data sources show that your household income was over the allowable income limit for these programs.

On August 3, 2016, your NYSOH account was updated.

On August 4, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost through NYSOH effective as of September 1, 2016.

Also on August 4, 2016, NYSOH issued a disenrollment notice stating that your MMC plan would be terminated effective August 31, 2016.

On August 18, 2016, you faxed an appeal request to NYSOH. You requested an appeal insofar as being disenrolled from your Medicaid coverage ([REDACTED]).

On January 12, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until January 12, 2017, to allow you submit your 2015 Form 1040 U.S. Individual Income Tax Return to NYSOH Appeals Unit. The first page of your 2015 Form 1040 and 2015 Form 8879 were received by NYSOH Appeals Unit that same day. The record is now complete and closed.

Findings of Fact

A review of the record supports the following findings of fact:

1. You testified that you want to be found eligible for Medicaid.
2. You testified and your NYSOH account reflect that you are applying for health insurance through for yourself.
3. According to your NYSOH account, you were initially determined eligible for Medicaid effective as of September 1, 2016.
4. On July 3, 2016, NYSOH issued a renewal notice stating that you could not enroll in your current health plan for the next coverage year because federal and state data sources show that your household income was over the allowable income limit for these programs.
5. According to your August 3, 2016 application, you expected to file a 2016 federal income tax return, with the tax status of single, and did not anticipate claiming any dependents on that tax return.
6. According to your August 3, 2016 application, you attested to an expected yearly income of \$62,000.00.
7. According to your August 3, 2016, your average monthly income was the same as your current monthly income.

8. You testified that \$62,000.00 represents for gross income for 2016 and expect your adjusted gross income to be between \$28,000.00 and \$29,000.00.
9. You testified that your monthly income varies between \$2,000.00 and \$3,000.00.
10. You reside in [REDACTED] County, New York.

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

Applicable Law and Regulations

Modified Adjusted Gross Income

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

“Adjusted gross income” is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, deductions that are attributable to a trade or business may be deductions from a taxpayers adjusted gross income (26 USC § 62 (a)(1)).

Medicaid:

Medicaid can be provided through the Marketplace 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 2016 FPL, which is \$11,880.00 for a one-person household (81 Fed. Reg. 4036).

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 Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or “whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility” (42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

Legal Analysis

The first issue is whether NYSOH properly determined that were not eligible for Medicaid as of August 3, 2016.

Medicaid can be provided through the Marketplace 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.

You expect to file your 2016 federal income tax return with the tax status of single and expect to claim no dependents on that tax return. Therefore, you are in a one-person tax household.

On your August 3, 2016 application, you attested to an income of \$62,000.00. The relevant FPL was \$11,880.00 for a one-person household on the date of that application. Since \$62,000.00 is 521.89% of the 2016 FPL, NYSOH properly found you to be not eligible for Medicaid on an expected annual income basis, using the information provided in your application.

You testified that \$62,000.00 represents your gross income and not your adjusted gross income. You expect your 2016 adjusted gross income to between

\$28,000.00 and \$29,000.00. Since \$28,000.00 is 235.69% of the 2016 FPL, your income exceeded the Medicaid income threshold.

Financial eligibility for Medicaid for applicants is based on current monthly household income and family size. To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,367.00 per month.

According to your August 3, 2016, your average monthly income was the same as your current monthly income, which was $(\$62,000.00/12)$ \$5,166.67. However, you testified that your monthly income in 2016 fluctuated between \$2,000.00 and \$3,000.00. Since your monthly income exceeds the Medicaid threshold amount, NYSOH properly determined you not eligible for Medicaid as of August 3, 2016.

The second issue is whether you were properly disenrolled from your Medicaid coverage August 31, 2016.

On September 3, 2015, NYSOH determined that you were eligible for Medicaid effective as of September 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every twelve months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.

On July 3, 2016, NYSOH issued a renewal notice stating that you could not enroll in your current health plan for the next coverage year because federal and state data sources show your household income was over the allowable income limit for these programs. NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days.

On August 3, 2016, you updated your account and was properly determined not eligible for Medicaid based on the analysis above. Therefore, NYSOH properly terminated your coverage after twelve months.

Decision

The August 4, 2016 eligibility determination is AFFIRMED, insofar as determining you not eligible for Medicaid.

The August 4, 2016 disenrollment notice is AFFIRMED.

Effective Date of this Decision: February 10, 2017

How this Decision Affects Your Eligibility

You were no longer eligible for Medicaid coverage as of August 31, 2016.

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 after the date 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 date 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:

- 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 August 4, 2016 eligibility determination is AFFIRMED, insofar as determining you not 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).

The August 4, 2016 disenrollment notice is AFFIRMED.

You were no longer eligible for Medicaid coverage as of August 31, 2016.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

A Copy of this Decision Has Been Provided To:

