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

Notice of Decision

Decision Date: February 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012377

[redacted]

Dear [redacted],

On January 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 9, 2016 eligibility determination notice.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: February 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000012377

[redacted]

Issue

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

> Did New York State of Health (NYSOH) properly determine that you and your spouse were not eligible for Medicaid as of August 9, 2016?

Procedural History

On August 8, 2016, you submitted an application for financial assistance through NYSOH.

On August 9, 2016, NYSOH issued an eligibility determination stating, in relevant part, that you were eligible and your spouse was conditionally eligible to enroll in the Essential Plan effective as of September 1, 2016.

Also on August 9, 2016, NYSOH issued an enrollment notice confirming, in relevant part, that as of August 8, 2016 you and your spouse were enrolled in an Essential Plan with an enrollment start date of September 1, 2016.

On October 4, 2016, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as the amount of financial assistance you and your spouse were determined eligible to receive.

On January 20, 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 closed at the end of the proceeding.

Findings of Fact

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

1. You testified that you want NYSOH to determine you and your spouse eligible for Medicaid.

2. You testified and your NYSOH account reflects that you are applying for health insurance through for yourself, your spouse, and youngest child.

3. According to your August 8, 2016 application, you expected to file a 2016 federal income tax return, with the tax status of married filing jointly, and expected to claim your two eldest children on that tax return.

4. You testified that you expect to claim all three of your children as dependents on your 2016 federal income tax return.

5. According to your August 8, 2016 application, you attested to an expected yearly income of $33,800.00.

6. According to your August 8, 2016, your household's average monthly income was the same as your current monthly income.

7. You reside in Genesee County, New York.

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 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)).

"Family size" means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

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 $28,440.00 for a five-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).

Legal Analysis

The first issue is whether NYSOH properly determined that were not eligible for Medicaid as of August 9, 2016.

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.

When calculating the household size for adults, the household consists of the taxpayer(s) plus all of individuals they expect to claim as tax dependents.

Your August 8, 2016 NYSOH application reflects that you expect to file your 2016 federal income tax return jointly with your spouse and expect to claim two dependents on that return. Consequently, NYSOH determined your and your spouse’s eligibility based on a four-person household.

However, you testified that expect to file your 2016 federal income tax return jointly with your spouse and expect to claim your three children as dependents on that return. Therefore, NYSOH determined your and your spouse’s eligibility using the wrong household size.

On your August 8, 2016 application, you attested to an income of $33,800.00. The relevant FPL was $28,440.00 for a five-person household on the date of that application.

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 $3,271.00 per month.

According to your August 8, 2016 application, your average monthly income was the same as your current monthly income, which was ($33,800.00/12) $2,816.67. Therefore, NYSOH improperly determined you and your spouse not eligible for Medicaid as of August 9, 2016.

The August 9, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to determine you and your spouse eligible for Medicaid as of August 9, 2016.

Decision

The August 9, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to determine you and your spouse eligible for Medicaid as of August 9, 2016.

Effective Date of this Decision: February 27, 2017

How this Decision Affects Your Eligibility

NYSOH improperly found you and your spouse not eligible for Medicaid as of August 9, 2016.

You and your spouse were Medicaid eligible as of August 9, 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 9, 2016 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to determine you and your spouse eligible for Medicaid as of August 9, 2016.

NYSOH improperly found you and your spouse not eligible for Medicaid as of August 9, 2016.

You and your spouse were Medicaid eligible as of August 9, 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:

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).