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

Notice of Decision

Decision Date: May 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014394

[redacted]

Dear [redacted],

On March 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's NYSOH's failure to determine you eligible for Medicaid effective July 1, 2016.

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

Decision

Decision Date: May 10, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014394

[redacted]

Issue

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

> Did NY State of Health (NYSOH) fail to determine you eligible for Medicaid coverage, effective July 1, 2016?

Procedural History

On October 5, 2016, NYSOH issued a notice stating that they denied your application for health insurance dated July 14, 2016, because you were asked to contact NYSOH by August 30, 2016 to review the information you provided in your application, and you failed to do so ([redacted] uploaded 10/6/2016).

On October 14, 2016, additional documentation was uploaded to your NYSOH account [redacted]

On October 25, 2016, NYSOH issued a notice stating that you had been notified that additional information was required to confirm your eligibility for health insurance through NYSOH. You have submitted documents; however, they cannot be reviewed because they were received more than thirty days after the due date [redacted] uploaded 10/26/2016).

On December 28, 2016, your NYSOH account was updated.

Also on December 28, 2016, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as the enrollment start of your MMC plan.

On December 29, 2016, NYSOH issued three notices:

(1) An eligibility determination notice stating that you were eligible for Medicaid effective as of December 1, 2016;
(2) An enrollment notice confirming that you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of February 1, 2017.
(3) A notice stating that your request for help with paying medical bills for the three-month period prior to your application has been received. However, additional information is required to determine your eligibility for Medicaid coverage from September 1, 2016 to November 30, 2016. The notice requested that you provide additional income documentation by January 12, 2017.

On January 1, 2017, you faxed additional documentation to NYSOH [redacted] uploaded 1/20/2017).

On January 18, 2017, you faxed additional documentation to NYSOH ([redacted] uploaded 1/27/2017).

On February 17, 2017, NYSOH issued a notice stating that you have submitted documentation to resolve an inconsistency; however, the documentation was insufficient to resolve the request. The notice directed you to provide additional income documentation to confirm your September 2016, October 2016, and November 2016 eligibility for Medicaid coverage [redacted].

On March 1, 2017, you faxed additional documentation to your NYSOH account [redacted] uploaded March 13, 2017).

On March 23, 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 March 30, 2017 to allow you to submit additional documentation.

On March 24, 2017, your NYSOH was systemically updated.

On March 25, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for: September 1, 2016 through September 30, 2016; October 1, 2016 through October 31, 2016, and November 1, 2016 through November 30, 2016.

On March 27, 2017, you faxed nine-pages of documents to NYSOH's Appeals Unit. That documentation has been incorporated into the record, and will be referred to as "Appellant Exhibit A." The record is now complete and closed.

Findings of Fact

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

1) On October 5, 2016, NYSOH issued a notice acknowledging that you submitted an application for health insurance on July 14, 2016. The notice stated that your application had been denied because you did not contact NYSOH by August 30, 2016, to review the information in your application [redacted].

2) On March 2, 2017, NYSOH uploaded an evidence packet to your account in anticipation of your telephone hearing [redacted] According to the Appeal Summary, you contacted NYSOH on August 23, 2016, to update your application but was unable to get in the account because of a system defect. A ticket was filed on that date [redacted] 8/23/2016).

3) According to the Appeal Summary, you requested an appeal on December 28, 2016, to effectuate your MMC on 1/1/2017. However, on January 31, 2017, you modified your appeal request to have your Medicaid coverage backdated to July 1, 2016 [redacted].

4) According to your NYSOH account, you are applying for health insurance for yourself.

5) According to your NYSOH account, you expected to file your 2016 federal income tax return, with the tax status of Head of Household (with qualifying individual), and you expected to claim your brother as a dependent on that tax return.

6) You testified that you expect to claim a $920.00 student loan interest deduction on your 2016 tax return.

7) You testified that you have three sources of income: [redacted];
[redacted].

8) On March 27, 2017, you faxed Profit and Loss statements for your house management, [redacted] to NYSOH's Appeals Unit. According to the income documentation you provided, your net income from:

[redacted] was $16.09 in July 2016;
was -$97.00 in August 2016;
([redacted] was $325.12 from July through August 2016;

(d) [redacted] was $4,147.00 from July through August 2016

(Appellant Exhibit A pgs. 2-3, 7-9).

9) You testified that you are concerned you will be assessed a tax penalty for not being enrolled in health insurance coverage from July 1, 2016 through November 30, 2016.

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

Applicable Law and Regulations

De Novo Review

The NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "*De novo review* means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

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" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

Subject to limitations, interest on a qualified educational loan can be deducted from adjusted gross income in an amount up to $2,500 in interest paid by taxpayers during the taxable year (26 USC § 221; see also 26 USC § 62 (17)).

Medicaid - Adults

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 2016 FPL, which is $16,020.00 for a two-person household (81 Federal Register 4036).

Legal Analysis

The issue under review is whether NYSOH failed to determine you eligible for Medicaid, effective July 1, 2016.

The record does not contain a notice of eligibility determination or redetermination regarding the issue of whether or not you qualify for Medicaid coverage for the months of July and August 2016. The appeal summary does contain an entry by NYSOH on January 31, 2017, that you were "requesting an appeal to have Medicaid coverage backdated to 07/01/2016."

Here, the lack of a notice of eligibility determination on the issue of your eligibility for Medicaid coverage for the months of July and August 2016 does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH's failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the notice of eligibility determination had it been issued. Therefore, the issue under review is whether you were properly denied Medicaid coverage for the months of July and August 2016.

The record reflects that you submitted an application for health insurance on July 14, 2016. Subsequently, on October 5, 2016, NYSOH issued a notice stating that your application had been denied because you did not contact NYSOH by August 30, 2016, to review the information in your application [redacted]. However, the record reflects that on August 23, 2016, you contacted NYSOH to update your application but was unable to get in the account because of a system defect.

On December 28, 2016, your NYSOH account was updated, and on December 29, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid effective as of December 1, 2016. Furthermore, on March 25, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for the months of September 2016, October 2016, and November 2016 [redacted].

According to your NYSOH account, you expected to file a 2016 federal income tax return, with the tax status of Head of Household (with qualifying individual), and expected to claim your brother as a dependent on that tax return. Therefore, you are in a two-person household.

Medicaid can be provided through NYSOH to adults who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size, which is a monthly income of $1,843.00 for a two-person household.

The record supports that you have three sources of income: [redacted]. You submitted documentation to NYSOH's Appeals Unit demonstrating that you earned: $16.09 from [redacted] in July 2016 and -$97.00 in August 2016; $325.12 from [redacted] in July and August 2016; $4,147.70 from July and August 2016. Lastly, you expect to claim a $920.00 student loan deduction on your 2016 federal income tax return.

Based on the available record, your July 2016 income is ($16.09 + ($325.12 / 2) + ($4,147.70 / 2) – ($920.00 / 12) $2,175.83, and your August 2016 income is (-$97.00 + ($325.12 / 2) + ($4,147.70 / 2) – ($920.00 / 12) $2,062.74.

Your case is RETURNED to NYSOH to determine your eligibility for Medicaid coverage based on a two-person household with a July 2016 income of $2,175.83, and an August 2016 income of $2,062.74.

The March 25, 2017, eligibility determination notice stating that you are eligible for Medicaid coverage for September 2016, October 2016, and November 2016 remains unchanged.

Decision

The March 25, 2017, eligibility determination notice stating that you are eligible for Medicaid coverage for September 2016, October 2016, and November 2016 remains unchanged.

Your case is RETURNED to NYSOH to determine your eligibility for Medicaid coverage based on a two-person household with a July 2016 income of $2,175.83, and an August 2016 income of $2,062.74.

Effective Date of this Decision: May 10, 2017

How this Decision Affects Your Eligibility

You are eligible for Medicaid coverage effective September 1, 2016.

Your case has been RETURNED to NYSOH to determine your eligibility for Medicaid coverage based on a two-person household with a July 2016 income of $2,175.83, and an August 2016 income of $2,062.74. NYSOH will notify you once this redetermination has been made.

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 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).

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 25, 2017, eligibility determination notice stating that you are eligible for Medicaid coverage for September 2016, October 2016, and November 2016 remains unchanged.

You are eligible for Medicaid coverage effective September 1, 2016.

Your case has been RETURNED to NYSOH to determine your eligibility for Medicaid coverage based on a two-person household with a July 2016 income of $2,175.83, and an August 2016 income of $2,062.74. NYSOH will notify you once this redetermination has been made.

Legal Authority

We are issuing this determination 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 1-855-355-5777 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 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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