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

Notice of Decision

Decision Date: March 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014836

[redacted]

Dear [redacted]

On March 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 12, 2017 eligibility determination notice.

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.

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: March 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014836

[redacted]

Issues

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

> Did NY State of Health properly determine your modified adjusted gross income?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On October 25, 2016, you submitted two applications for financial assistance. The first application listed an annual household income of $14,581.00 and the second application listed an annual household income of $5,901.75.

On October 26, 2016, NY State of Health (NYSOH) issued a notice stating that the income information in your application does not match information received from state and federal data sources. You were asked to provide proof of your income by November 9, 2016 so that your eligibility could be determined.

On October 31, 2016, you faxed in a copy of your 2015 income tax return listing an adjusted gross income of $9,597.00 and a typed list of your income and expenses for January through October 2016.

On November 15, 2016, the documentation you submitted was invalidated because you submitted business records without gross sales listed.

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On November 16, 2016, NYSOH issued a notice stating that the documentation NYSOH reviewed did not confirm the information in your application. You were asked to provide additional documentation of your income by December 9, 2016. On December 15, 2016, NYSOH issued a notice stating that the documentation NYSOH reviewed did not confirm the information in your application. You were asked to provide additional documentation of your income by January 8, 2017.

On November 21, 2016, you faxed a letter from your employer stating that so far in 2016 you earned a gross amount of $17,968.38 and a typed list of your income and expenses for January through October 2016.

On December 14, 2016, the documentation you submitted was invalidated because the letter you submitted listed your year to date income and did not state your weekly, monthly, or annual gross income.

On December 22, 2016, you faxed in a letter from your employer stating that you do not receive regular paychecks and between September 1, 2016 and November 30, 2016 you were paid $708.45.

On January 11, 2017, the documentation you submitted was verified and the income information in your application was updated to $27,565.38.

On January 12, 2017 NYSOH issued a notice of eligibility determination, based on the January 11, 2017 application, stating that you were eligible to receive up to $280.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective February 1, 2017. That notice also stated that you were not eligible for Medicaid because your income was over the allowable income limits for that program.

On January 13, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as you were not eligible for Medicaid.

On March 7, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [redacted] [redacted] acted as your authorized representative and assisted you in your testimony. The record was developed during the hearing and held open until April 15, 2017, to allow you time to submit your 2016 income tax return and a letter from your former employer stating what your monthly income was for December 2016 and January 2017.

On March 15, 2017, NYSOH Appeals Unit received a fax containing a letter from your employer stating your earnings from December 2016 and January 2017. On March 16, 2017, NYSOH Appeals Unit received a fax containing a copy of your 2016 income tax return. The faxes were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

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Findings of Fact

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

1) You testified that you are seeking to be found eligible for Medicaid through this appeal.

2) You testified that you expect to file your 2016 and 2017 taxes with a tax filing status of single and will claim no dependents on either of those tax returns.

3) You are seeking insurance for yourself.

4) On October 31, 2016, you submitted a copy of your 2015 income tax return stating that you had a total income of $13,017.00 and deductions of $9,597.00.

5) On November 21, 2016, you faxed a letter from your employer stating that so far in 2016 you earned a gross amount of $17,968.38

6) The application that was submitted on January 11, 2017 listed annual household income of $27,565.38, consisting of earned income of $17,968.38, additional income in the amount of $13,017.00, and deductions of $3,420.00.

7) You testified that the income amounts listed in the January 11, 2017 application were not correct.

8) You testified that your 1099 tax form for 2016 listed an income of $19,000.00, before deductions.

9) On March 16, 2017, you faxed a copy of your 2016 income tax return showing a gross income of profit from business of $19,199.00.

10) You testified that you have a lot of business expense deductions associated with your employment.

11) Your 2016 income tax return states total expenses from your business of $14,530.00.

12) Your 2016 income tax return states that your adjusted gross income for 2016 is $2,065.00.

13) On March 15, 2016, you faxed a letter from your employer stating that your earnings from December 2016 and January 2017 were $0.00.

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14) You testified that so far in 2017 you have not received any income.

15) Your application states that you live in [redacted] 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)), NY Social Services 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).

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)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Legal Analysis

The first issue is whether NYSOH properly determined your modified adjusted gross income.

On October 25, 2016, you submitted two applications for financial assistance. The first application listed an annual household income of $14,581.00 and the second application listed an annual household income of $5,901.75. NYSOH was unable to verify your attested income based on the information they were receiving from data sources. You were subsequently asked to provide income documentation to confirm your attestation.

On October 31, 2016, you submitted a copy of your 2015 income tax return stating that you had a total income of $13,017.00 and deductions of $9,597.00. On November 21, 2016, you faxed a letter from your employer stating that so far in 2016 you earned a gross amount of $17,968.38.

Household income for the purposes of calculating a person's eligibility for financial assistance to help pay for the costs of health insurance through the NYSOH, consists of the Modified Adjusted Gross Income of all tax filers in a household who are required to file a tax return.

On January 11, 2017, NYSOH updated your application listing an annual household income of $27,565.38. You testified that the income amounts listed in the January 11, 2017 application was not correct.

The record indicates that the income NYSOH entered into the January 11, 2017 application consisted of earned income of $17,968.38, additional income in the amount of $13,017.00, and deductions of $3,420.00. The amounts entered appear to be based on the income documentation you submitted on October 31, 2016 and November 21, 2016.

Therefore, NYSOH erred in listing income from both documents. NYSOH should have relied on either the letter from your employer stating that you had earned $17,968.38 in 2016 or the income stated in your 2015 income tax return. Verifying both documents and including income from 2015 and 2016 as expected income for 2017 was incorrect.

Accordingly, the January 12, 2017 eligibility determination notice is RESCINDED because it was based on an incorrectly calculated modified adjusted gross income.

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

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 that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,395.00 for a one-person household.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size, which is $1,367.00 per month.

You testified that so far in 2017 you have not received any income. On March 15, 2017, you faxed a letter from your employer stating that your earnings from December 2016 and January 2017 were $0.00.

Since the January 12, 2017 eligibility determination has been rescinded, and you provided credible testimony and documentation confirming that in January 2017 you earned $0.00, your case is RETURNED to NYSOH to redetermine your eligibility as of January 1, 2017 based on a household of one-person, residing in [redacted] County, with a household income from January 2017 of $0.00.

Decision

The January 12, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility as of January 1, 2017, based on a household of one-person, residing in [redacted]County, with a household income from January 2017 of $0.00.

Effective Date of this Decision: March 28, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

NYSOH improperly calculated your household income.

Your case is being sent back to NYSOH to redetemrine your eligibility based on your testimony and documentation.

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 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 January 12, 2017 eligibility determination notice is RESCINDED.

NYSOH improperly calculated your household income.

Your case is RETURNED to NYSOH to redetermine your eligibility as of January 1, 2017, based on a household of one-person, residing in [redacted] County, with a household income from January 2017 of $0.00.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetemrine your eligibility based on your testimony and documentation.

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 1-855-355-5777 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 निःशुल्क 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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