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

Notice of Decision

Decision Date: July 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016898

Dear [redacted],

On July 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 28, 2017 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.

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: July 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016898

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 and your spouse were eligible for Medicaid effective February 1, 2017?

Procedural History

On January 4, 2017, NYSOH received your updated application for financial assistance with health insurance.

On January 6, 2017, NYSOH issued a notice stating that the income information you entered into your application did not match what NYSOH received from state and federal data sources and more information was needed to confirm the information in your account. This notice directed you to submit income documentation for you and your spouse by January 19, 2017.

Also on January 6, 2017, NYSOH issued an eligibility determination stating that your children were conditionally eligible for Medicaid, effective January 1, 2017. This notice further directed you to submit proof of citizenship status and Social Security numbers for your children by April 4, 2017, and income documentation for yourself and your spouse by January 19, 2017.

No income documentation was received by NYSOH by January 19, 2017.

On February 14, 2017, NYSOH ran an application on your household's behalf.

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).

On February 15, 2017, NYSOH issued an eligibility determination stating that your spouse was eligible to enroll in a full price qualified health plan, effective March 1, 2017. This notice further stated that this was because NYSOH had failed to receive the information to verify your income by the due date.

Also on February 15, 2017, NYSOH issued a notice stating that the income information you entered into your application did not match what NYSOH received from state and federal data sources and more information was needed to confirm the information in your account in order to determine your eligibility. This notice further directed you to submit income documentation by February 18, 2017.

On February 16, 2017, you uploaded a letter from your employer to your NYSOH account.

On February 17, 2017, you uploaded three paystubs as well as your children's Social Security cards to your NYSOH account.

On February 27, 2017, NYSOH verified your children's Social Security cards and an updated application was submitted on your household's behalf.

On February 28, 2017, NYSOH issued an eligibility determination stating that you and your spouse were eligible for Medicaid, and your children remained eligible for Medicaid, effective February 1, 2017.

On March 2, 2017, NYSOH issued a plan enrollment notice confirming your and your spouse's enrollment in a Medicaid Managed Care plan, effective April 1, 2017.

On March 16, 2017, you spoke to NYSOH's Account Review Unit and appealed your and your spouse's eligibility determination in so far as you and your spouse were found eligible for Medicaid, and not the Essential Plan.

On March 21, 2017, NYSOH issued an eligibility determination stating that you and your spouse were eligible for the Essential Plan with a $20.00 monthly premium, for a limited time, effective February 1, 2017. This notice further stated that you and your spouse had been granted Aid to Continue until a decision was made on your appeal.

Also on March 21, 2017, NYSOH issued a plan enrollment notice confirming your and your spouse's enrollment in an Essential Plan with a $20.00 monthly premium, effective February 1, 2017.

On June 30, 2017, you were scheduled to have a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You requested that day that the hearing be adjourned to a later date; which was granted.

On July 10, 2017, you uploaded three documents to your NYSOH account.

On July 10, 2017, you had an adjourned hearing with a Hearing Officer from NYSOH's Appeals Unit. Under oath, you waived your right to formal notice of the hearing. 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 2017 taxes with a tax filing status of married filing jointly. You will claim two dependents on that tax return.

2) The application that was submitted on January 4, 2017 listed annual household income of $25,000.00, consisting of income you earn from your employment. You testified that this amount was incorrect for 2017 because this was the amount you made last year.

3) On February 16, 2017, you uploaded a letter from your employer, dated January 26, 2017, to your NYSOH account. This letter stated that you were currently employed with the company.

4) On February 17, 2017, you uploaded three weekly paystubs to your NYSOH account. The paystubs were dated January 17, 2017, January 27, 2017, and February 3, 2017.

5) On February 17, 2017, you uploaded copies of your children's Social Security cards.

6) On February 27, 2017, an NYSOH representative reviewed your children's Social Security cards and updated your application. The representative did not review your income documentation and did not update the income in your application.

7) You testified that the [redacted] company you work for found a better job, and that this year you expect your income to be around $40,000.00.

8) You testified that you work for a [redacted] company, so your income varies depending on the jobs that the company is hired for.

9) You testified that you are paid on a weekly basis.

10) On July 10, 2017, you uploaded income documentation to your NYSOH account. This documentation included four weekly paystubs; dated June 9, 2017 for a gross amount of $1,066.00, June 16, 2017 for a gross amount of $949.00, June 23, 2017 for a gross amount of $1040.00, and June 30, 2017 for a gross amount of $1040.00.

11) Your application states that you will not be taking any deductions on your 2017 tax return.

12) Your application states that you live in [redacted].

13) You testified that you would like you and your spouse to be found eligible for the Essential Plan, and not Medicaid.

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

Applicable Law and Regulations

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

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 2017 FPL, which is $24,600.00 for a four -person household (82 Fed. Reg. 8831).

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).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is $24,300.00 for a four -person household (81 Fed. Reg. 4036).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Legal Analysis

The issue is whether NYSOH properly determined that you and your spouse were eligible for Medicaid, effective February 1, 2017.

On January 4, 2017, NYOSH received your application for financial assistance with health insurance, this application listed an annual household income of $25,000.00.

For individuals whose income is needed to calculate eligibility, NYOSH must request data that will allow NYOSH to verify the individuals household income.

If NYOSH cannot verify the income information required to determine eligibility, they must attempt to resolve the inconsistency by giving the applicant the opportunity to submit satisfactory documentary evidence.

NYSOH was unable to verify the income amount you had listed in your January 4, 2017 application. As a result, on January 6, 2017, NYSOH issued a notice asking you to submit income documentation for you and your spouse to confirm the income that was listed in your application by January 19, 2017.

No income documentation was received by January 19, 2017. Subsequently, on February 14, 2017, NYSOH ran a new application on your household's behalf.

On February 15, 2017, NYSOH issued another notice stating that the information in your application did not match federal and state data sources. As a result, you were again asked to submit income documentation for you and your spouse to confirm the income that was listed in your application.

On February 16, 2017 and February 17, 2017, you uploaded income documentation to your NYSOH account consisting of a letter from your employer and three paystubs.

Also on February 17, 2017, you uploaded copies of your children's Social Security cards.

On February 27, 2017, an NYSOH representative reviewed your children's Social Security cards and updated your application. The representative did not review your income documentation and did not update the income in your application. As a result, an application was submitted stating that your annual household income was $25,000.00.

On February 28, 2017, NYSOH issued an eligibility determination, based on the February 27, 2017 application, stating that you and your spouse were eligible for Medicaid, effective February 1, 2017.

However, NYSOH failed to review the income documentation you provided to confirm your annual household income. During the hearing, you testified that the $25,000.00 you provided in your January 4, 2017 application, which was used when NYSOH reran your eligibility on February 27, 2017, was based on how much you earned in 2016 and was therefore not an accurate representation of

what you expect to earn in 2017. You credibly testified that your expected annual income for 2017 is $40,000.00 and provided additional documentation on July 10, 2017 to support your testimony.

Therefore, the income amount that was relied on in the February 28, 2017 eligibility determination is not supported by the record and the notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household's eligibility, as of February 27, 2017, based on a household of four people, residing in . NYSOH is directed to determine your household's annual expected income based on the documentation you provided on July 10, 2017 (See Document # and #), and to notify you accordingly.

Decision

The February 28, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household's eligibility, as of February 27, 2017, based on a household of four people, residing in . NYSOH is directed to determine your household's annual expected income based on the documentation you provided on July 10, 2017 (See Document # and #), and to notify you accordingly.

Effective Date of this Decision: July 18, 2017

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to redetermine your household's eligibility in accordance with your testimony and evidence presented at the hearing.

NYSOH will notify you accordingly.

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.

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).

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

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The February 28, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household's eligibility, as of February 27, 2017, based on a household of four people, residing in [redacted]. NYSOH is directed to determine your household's annual expected income based on the documentation you provided on July 10, 2017 (See Document # [redacted] and # [redacted]), and to notify you accordingly.

Your case is being sent back to NYSOH to redetermine your household's eligibility in accordance with your testimony and evidence presented at the hearing.

Legal Authority

We are sending you this notice in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

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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.

□□□□□ (Bengali)

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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.

(Urdu)اردو

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.

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).