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

Notice of Decision

Decision Date: August 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017810

[redacted]

Dear [redacted],

On July 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 22, 2017 and April 5, 2017 eligibility determinations.

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
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Decision

Decision Date: August 16, 2017

NY State of Health Account ID: [redacted]
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[redacted]

Issues

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

> Did NY State of Health properly determine that your family was eligible for Medicaid, effective March 1, 2017?
>
> Did NY State of Health properly determine that your family was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until February 28, 2018?

Procedural History

On February 22, 2017, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance.

On February 23, 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, and your children were eligible for a Child Health Plus plan with a $9.00 monthly premium, for a limited time, effective April 1, 2017. This notice further directed you to submit household income documentation for you and your spouse by March 12, 2017, and to submit household income documentation for your children by April 23, 2017.

On March 12, 2017, you uploaded one document to your NYSOH account.

On March 21, 2017, NYSOH validated the income documentation you submitted, and ran an updated application on your household's behalf.

On March 22, 2017, NYSOH issued an eligibility determination stating that your family were eligible for Medicaid because your household income was at or below the allowable income limit. This eligibility was effective as of March 1, 2017.

On April 4, 2017, NYSOH received your updated application for health insurance.

On April 5, 2017, NYSOH issued an eligibility determination stating that your family was no longer eligible for Medicaid. However, your family's Medicaid coverage would continue until February 28, 2018 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of April 1, 2017.

On April 6, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your family's enrollment in Medicaid had been continued.

On April 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, and your children were eligible for a Child Health Plus plan with a $9.00 monthly premium, for a limited time, effective April 1, 2017. This notice further stated that your family had been granted Aid to Continue until a decision was made on your appeal.

Also on April 21, 2017, NYSOH issued a plan enrollment notice confirming your and your spouse's enrollment in the Essential Plan, and your children's enrollment in a Child Health Plus plan, effective April 1, 2017.

On July 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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 expect to file your 2017 federal income tax return as married filing jointly, and claim your three children as dependents.

2) According to the February 22, 2017 application, you attested to an expected annual household income of $52,000.00.

3) You testified that you and your spouse are part owners of a [redacted] and that you both take home $500.00 every two weeks.

4) The record indicates that, on March 12, 2017, you uploaded your 2016 federal tax return which lists an adjusted gross income of negative $200,792.00.

5) On March 21, 2017, NYSOH validated the income documentation, updated your expected household income from $52,000.00 to negative $113,956.00, and an application was submitted on your family's behalf.

6) You testified that your adjusted gross income is in the negative on your tax documentation because of the depreciation of your property, and the nature of your business.

7) You testified that you and your spouse take home $52,000.00 combined each year, and that your tax return is not an accurate reflection of the amount of income you and your spouse actually take home.

8) According to the April 4, 2017 application, you attested to an expected household income of $52,000.00.

9) You testified that you would like your family to remain in the coverage they have now because you are satisfied with their care and would like to keep continuity with their doctors.

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).

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.

Medicaid for Applicants between the Ages of 1 to 65

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 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)).

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

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 2017 FPL, which is $28,780.00 for a five -person household (82 Fed. Reg. 8831).

Generally, most applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-

month period is referred to as “continuous coverage” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your family was eligible for Medicaid effective March 1, 2017.

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.

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.

You updated your application on February 22, 2017 and listed an expected household annual income of $52,000.00. The income amount you entered into this application did not match federal and state data sources. As a result, NYSOH asked that you submit additional income documentation to confirm your household’s eligibility.

On March 12, 2017, you uploaded a copy of your 2016 tax return to your NYSOH account. On March 21, 2017, NYSOH validated the document, updated your income from $52,000.000 to $ -113,956.00, and an application for financial assistance was submitted on your family’s behalf.

You testified that due to the nature of your business, and the depreciation of your property, the amount listed in the March 21, 2017 application was an accurate reflection of your expected household income after deductions. However, you further testified that your tax document is not an accurate reflection of what you and your spouse actually receive in take home income a year.

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code. Your adjusted gross income is your federal taxable income minus specific deductions. Therefore, your expected annual household income is the amount listed under your adjusted gross income (or line 37) on your federal tax return.

Your family is in a five-person household. According to the record, you expect to file your 2017 tax return as married filing jointly and claim three children as dependents.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 64 who meet the non-financial requirements and have a household MAGI that is at or below 138% of the FPL for the applicable family size. Medicaid can be provided through NYSOH to children between the ages of 1 and 19 who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 154% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $28,780.00 for a five - person household. Since $-113,956.00 is 0% of the 2017 FPL, NYSOH properly found your family to be eligible for Medicaid on an expected annual income basis, using the information provided in your income documentation.

Since the March 22, 2017 eligibility determination properly stated that, based on the income documentation you provided, your family was eligible for Medicaid, it is correct and is AFFIRMED.

The second issue is whether NYSOH properly determined that your family was no longer eligible for Medicaid, but would continue to receive Medicaid coverage until February 28, 2018.

You testified that you updated your income in your April 4, 2017 application because you and your spouse technically receive $52,000.00 a year in income, which is above the Medicaid limit.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% or 154% of the FPL. This provision is called “continuous coverage.”

Credible evidence confirms that your family was eligible for Medicaid effective March 1, 2017, and that even though your estimated household annual income increased when you modified your application on April 4, 2017, your family remains enrolled in Medicaid for the remainder of your 12-month eligibility period.

Therefore, the April 5, 2017 eligibility determination is correct and is AFFIRMED.

Decision

The March 22, 2017 and April 5, 2017 eligibility determinations are AFFIRMED.

Effective Date of this Decision: August 16, 2017

How this Decision Affects Your Eligibility

Your family's Medicaid coverage, which began on March 1, 2017, continues until February 28, 2018, barring subsequent changes in your eligibility.

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):

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 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 22, 2017 and April 5, 2017 eligibility determinations are AFFIRMED.

Your family's Medicaid coverage, which began on March 1, 2017, continues until February 28, 2018, barring subsequent changes in your eligibility.

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।

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).

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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