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

Notice of Decision

Decision Date: September 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018389

[redacted]

Dear [redacted],

On August 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 25, 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: September 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018389

[redacted]

Issue

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

Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On April 25, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan with a monthly premium of $20.00, effective June 1, 2017. That notice also stated that individuals that qualify for the Essential Plan are not eligible to enroll in other coverage.

On April 26, 2017, you spoke to NYSOH's Account Review Unit and appealed the April 25, 2017 eligibility determination insofar as you are seeking to be determined eligible for Medicaid.

On August 16, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until August 30, 2017, to allow you to submit income documentation.

On August 23, 2017, you uploaded to your NYSOH account the following: 3 earnings statements from April 2017 and a commission statement from your employer [redacted]; and a letter stating your April 2017 income from your partner/co-owner from [redacted]. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

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 single. You will claim no dependents on that tax return.

2) You are seeking insurance for yourself.

3) The application that was submitted on April 24, 2017 listed annual household income of $23,256.00, consisting of $25,465.00 you earn from your employment minus $2,209.00 in deductions.

4) You testified that you are a part owner of a business named [redacted] and that you had minimal income from the business during April 2017.

5) You testified that you are also employed by [redacted] and that you are paid on a commission basis. You testified that during 2016 and 2017 you earned almost no income from [redacted] because you have been concentrating on increasing sales for [redacted].

6) On August 23, 2017, you uploaded the following income documentation:

    a. Earnings statement dated April 13, 2017 from [redacted] reflecting total earnings of $0.00.
    b. Earnings statement dated April 20, 2017 from [redacted] reflecting total earnings of $0.00.
    c. Earnings statement dated April 27, 2017 from [redacted] reflecting total earnings of $0.00.
    d. Commission statement from [redacted] reflecting total earnings of $0.00 for April 2017.
    e. Letter from co-owner/partner [redacted] stating that your earnings from [redacted] for the month of April 2017 was $250.00.

7) You testified that you had no other income during April 2017.

8) Your application states that you will be taking a deduction for student loan interest in the amount of $1,540.00 and a deduction for self-employment in the amount of $669.00 on your 2017 tax return.

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

10) You testified that you are seeking a redetermination of your Essential Plan eligibility insofar as you are seeking to be redetermined eligible for Medicaid.

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 2017 FPL, which is $11,948.00 for a one-person household (82 Federal Register 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).

Legal Analysis

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

You are in a one-person household for purposes of this analysis because you file your taxes with a tax filing status of single and claim no dependents on your tax return.

The application that was submitted on April 24, 2017 listed annual household income of $23,256.00, consisting of $25,465.00 you earn from your employment minus $2,209.00 in deductions.

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 $11,948.00 for a one-person household. Since $23,256.00 is 194.64% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

The income documentation you uploaded supports that you had no earnings from [redacted] and that the only earnings you received during the month of April 2017, were from [redacted] in the gross amount of $250.00. Therefore, the record indicates that in the month of April 2017, you had a monthly household income of $250.00.

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 $1,387.00 per month. Since the income documentation you provided shows that you earned $250.00 in April 2017 you do qualify for Medicaid on the basis of monthly income as of the date of your application.

The April 25, 2017 eligibility determination notice determined that you were not eligible for Medicaid because your household income of $1,938.00 that month was over the allowable monthly income limit of $1,387.00. Since the income amount for April 2017 calculated by NYSOH is incorrect and not supported by the record, the notice is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the month of April 2017, to which you testified under oath, your case is RETURNED to NYSOH to consider your request for Medicaid coverage based on a household size of one person and household income of $250.00 for the month of April 2017.

Decision

The April 25, 2017 eligibility determination notice regarding your eligibility for Medicaid is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for Medicaid coverage based on a household size of one person and household income of $250.00 for the month of April 2017, and to notify you accordingly.

Effective Date of this Decision: September 12, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for Medicaid. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing. NYSOH will notify you once a redetermination is 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 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 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 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 April 25, 2017 eligibility determination notice regarding your eligibility for Medicaid is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for Medicaid coverage based on a household size of one person and household income of $250.00 for the month of April 2017, and to notify you accordingly.

This is not a final determination of your eligibility for Medicaid. Your case is sent back to NYSOH to redetermine your eligibility based on the evidence you presented at the hearing. NYSOH will notify you once a redetermination is made.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

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).

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)

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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।

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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