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

Notice of Decision

Decision Date: October 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018459

[redacted]

Dear [redacted],

On August 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's failure to issue a timely 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 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: October 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018459

[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 provide a timely determination of your eligibility for Medicaid?

Procedural History

On January 19, 2017, you submitted an application for financial assistance.

On January 20, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to provide additional proof of your current income by February 3, 2017, to confirm your eligibility.

On January 30, 2017, you uploaded documentation to your account (*see* Document [redacted]).

On February 9, 2017, NYSOH issued a notice stating that the documentation reviewed did not confirm the information in your application. The notice directed you to provide more proof of income by March 5, 2017, to confirm your eligibility.

On February 10, 2017, you uploaded documentation to your account (*see* Documents [redacted]; [redacted]).

On February 23, 2017, NYSOH issued a notice stating that the documentation reviewed did not confirm the information in your application. The notice directed

you to provide more proof of income by March 20, 2017, to confirm your eligibility.

On March 31, 2017, you uploaded documentation to your account (*see* Documents [redacted]).

On April 15, 2017, your NYSOH account was systemically updated.

On April 16, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost through NYSOH, effective May 1, 2017.

On April 17, 2017, your NYSOH account was updated.

Also on April 17, 2017, you uploaded additional documentation to your account (*see* Document [redacted]).

On April 18, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to provide additional proof of your current income by May 2, 2017, to confirm your eligibility.

On April 21, 2017, NYSOH issued a notice stating that the documentation reviewed did not confirm the information in your application. The notice directed you to provide more proof of income by May 17, 2017, to confirm your eligibility.

On April 27, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as you assert that NYSOH failed to provide a timely eligibility determination.

On August 10, 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 to allow you to submit additional income documentation to NYSOH's Appeals Unit.

On August 14, 2017, you submitted five-pages of documentation to NYSOH Appeals Unit. That documentation has been made part of the record as "Appellant Exhibit A." The record is complete and closed.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are applying for yourself.

2) You testified that you want to be determined eligible for Medicaid.

3) According to your NYSOH account and testimony, you expect to file a 2017 federal income tax return, with the tax status of single, and do not expect to claim any dependents on that return.

4) According to your January 19, 2017 and April 17, 2017 applications, you attested that your only source of income in 2017, will be from [redacted].

5) On January 30, 2017, you submitted to NYSOH:

   (a) receipts for [redacted] from January 18, 2017 and January 20, 2017;
   (b) [redacted] transactions from January 18, 2017 through January 21, 2017;
   (c) [redacted], dated January 24, 2017, for the Town of [redacted];
   (d) Receipt for a [redacted], dated January 20, 2017, for the Town of [redacted]
   (e) [redacted], dated January 23, 2017, for the Town of [redacted];
   (f) Check receipt from the Town of [redacted] for a [redacted]

   (*see* Document [redacted]).

6) On February 10, 2017, March 31, 2017, and April 17, 2017, you submitted commission paychecks from [redacted]. You were issued:

   (a) $750.00 on November 10, 2016;
   (b) $750.00 on November 18, 2016;
   (c) $2,070.60 on January 13, 2017;
   (d) $765.60 on March 3, 2017;
   (e) $546.00 on March 10, 2017;
   (f) $350.90 on March 31, 2017

   (*see* Documents [redacted]).

7) On March 31, 2017, you submitted a hand-written itemized list of your income and expenses. You listed the following sources of income and expenses:

(a) [redacted]: year-to-date income of $3,382.20 and expenses of $1,393.15;
(b) Received vacation pay from [redacted] however, you were no longer employed there;
(c) You were no longer employed at [redacted]

(*see* Document [redacted]).

8) On March 31, 2017, you submitted a statement of account from [redacted], dated March 17, 2017, stating that your net earnings for the current period was $0.00 and year-to-date was $284.49 (*see* Document [redacted]).

9) On March 31, 2017, you submitted your 2016 Form 1040 U.S. Individual Income Tax Return and 2016 IT-201 New York State Resident Income Tax Return with the supplemental schedules and forms (*see* Documents [redacted]).

10) You testified that the adjusted gross income, stated on your 2016 Form 1040 U.S. Individual Income Tax Return, does not represent your 2017 expected income.

11) You testified that you made an early withdrawal from your tax-deferred individual retirement account (IRA) in June 2017.

12) You testified that your income from [redacted] and withdrawals from your tax-deferred individual retirement account were your only sources of income in May 2017, June 2017, and July 2017.

13) On August 14, 2017, you submitted income documentation for the months of May 2017, June 2017, and July 2017. The documentation demonstrates that:

(a) In May 2017, you received $319.00 from [redacted] and expected to claim $2,632.34 in business expenses;

(b) In June 2017, you withdrew $11,111.11 from your tax-deferred IRA; expected to claim $2,000.20 in business expenses and $1,111.11 for taxes and fees on an early withdrawal from an IRA;

(c) Your year-to-date withdrawals from your IRA was $11,111.11;

(d) In July 2017, you did not receive any income, and were claiming $3,148.53 in business expenses.

(Appellant Exhibit A, pp. 2-5).

14) According to your NYSOH account, you reside in [redacted], New York.

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

Applicable Law and Regulations

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.

Generally, the amount paid or distributed out of an individual retirement plan shall be included in gross income by the payee or distributee in the year they are received (26 USC § 408(d), IRS Publication 590-B (2016)).

Medicaid - Eligibility

Medicaid can be provided through the Marketplace 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 that is at or below 138% of the federal poverty for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.603(d)(4)), N.Y. Soc. Serv. Law § 366(1)(b)).

On the date of your application, that was the 2017 FPL, which is $12,060.00 for a one-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).

Medicaid – Verification Process

NYSOH may accept self-attestation of information needed to determine the income eligibility of an individual for Medicaid (42 CFR § 435.945(a)). NYSOH must request information relating to financial eligibility from other agencies in the State, other States, and Federal programs to the extent NYSOH determines such information is useful to verifying the financial eligibility for an individual (42 CFR § 435.948(a)).

An individual must not be required to provide additional information or documentation unless information needed by NYSOH cannot be obtained electronically or the information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual (42 CFR § 435.952(c)).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time-period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

Legal Analysis

The issue under review is whether NYSOH failed to provide you with a timely eligibility determination following your January 19, 2017 application for financial assistance.

For all individuals whose income is needed to calculate a 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 by giving the applicant the opportunity to submit satisfactory documentary evidence.

On January 19, 2017, you applied for financial assistance through NYSOH. In that application, you attested that your only source of income was from [redacted]. The income that you attested to in that application did not match the federal and state data sources. As a result, NYSOH issued you a notice on January 20, 2017, instructing you to submit additional of proof of income to NYSOH to confirm your eligibility for financial assistance. The notice directed you to report all the income for your household and provided an acceptable documentation list (*see* Document [redacted]).

On January 30, 2017, you submitted copies of [redacted]; [redacted] transactions, and [redacted] and [redacted] (*see* Document [redacted]). The documentation reflects that all of the expenses were incurred in the month of January 2017. Further, no income documentation or written explanation of your income was provided to NYSOH at that time.

On February 10, 2017, March 31, 2017, you submitted commission paychecks from [redacted]. The paychecks indicated that you were issued: $750.00 on November 10, 2016; $750.00 on November 18, 2016; $2,070.60 on January 13, 2017; $765.60 on March 3, 2017; and $546.00 on March 10, 2017 (*see* Documents [redacted]; [redacted]).

On March 31, 2017, you submitted your 2016 Form 1040 U.S. Individual Income Tax Return and 2016 IT-201 New York State Resident Income Tax Return with the supplemental schedules and forms (*see* Documents [redacted]).

You testified that the adjusted gross income stated on your 2016 income tax returns did not reflect what you expect your 2017 adjusted gross income to be. Therefore, your 2016 tax documentation was insufficient to satisfy NYSOH's request for additional income documentation.

On March 31, 2017, you submitted a hand-written itemized list of your income and expenses. You listed the following sources of income and expenses: (1)

[redacted], year-to-date income of $3,382.20 and expenses of $1,393.15; (2) Vacation pay from [redacted], and (3) You were no longer employed at [redacted]. On the same day, you submitted a statement of account from [redacted], dated March 17, 2017, stating that your net earnings for the current period was $0.00 and year-to-date was $284.49 (*see* Document [redacted]).

The record reflects that you did not submit any documentation to demonstrate when [redacted] issued you the vacation pay, and the amount that was issued. Without proper documentation of your vacation pay from [redacted] your monthly and expected yearly income could not be properly calculated.

NYSOH must provide adult applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, the time period begins on the date of the completed application and ends on the date NYSOH notifies the applicant of its decision.

The income documentation you submitted was insufficient to satisfy NYSOH's request for additional income documentation. Without sufficient income documentation, NYSOH was unable to calculate your eligibility for financial assistance. Therefore, it is concluded that NYSOH did not fail to issue you a timely eligibility determination.

During the hearing, you testified that your only sources of income for the last three months were from [redacted] and withdrawals from your tax-deferred IRA. You were instructed to provide monthly income and expense statements from your employment with [redacted], and documentation of your IRA withdrawals.

On August 14, 2017, you submitted income and expense statements, for the last three months, for your employment with [redacted]. The statements assert that you received: $319.00 and would claim $2,632.34 in expenses for May 2017; $0.00 and would claim $2,000.20 in expenses for June 2017; and $0.00 and would claim $3,148.53 in business expenses in July 2017 (*see* Appellant Exhibit A, pp. 2-4).

Also on August 14, 2017, you submitted documentation indicating that you withdrew $11,111.11 from your tax-deferred IRA in June 2017, and expected to claim the $1,111.11, for taxes and fees on that withdrawal, as a deduction on your tax return.

The record reflects that you expect to file a 2017 federal income tax return, with the tax status of single, and did not expect to claim any dependents on that tax return. Therefore, you are in a one-person household.

On the date of your application, the relevant FPL was $12,060.00 for a one-person household. 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. Therefore, an adult in a one-person household is eligible for Medicaid if their expected household income is below $16,643.00.

Based on the available record, your expected gross income is ($319.00 for a 3-month period X 4 quarterly periods) $1,276.00 + 11,111.11 IRA withdrawal) $12,387.11. As such, without regard to what expenses you expect to claim on your federal income tax return, your income is below the Medicaid threshold.

Therefore, your case is RETURNED to NYSOH to recalculate your eligibility for financial based on a one-person household, with an expected household income of $12,387.11, for an individual residing in [redacted], New York.

Decision

NYSOH did not fail to issue you a timely determination for your eligibility for Medicaid.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial based on a one-person household, with an expected household income of $12,387.11, for an individual residing in [redacted], New York.

Effective Date of this Decision: October 26, 2017

How this Decision Affects Your Eligibility

NYSOH did not fail to issue a timely notice of eligibility determination since the documentation you submitted was insufficient to calculate your eligibility for financial assistance.

Your case has been returned to NYSOH to determine your eligibility for financial assistance and issue an eligibility determination notice.

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

NYSOH did not fail to issue you a timely determination for your eligibility for Medicaid.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial based on a one-person household, with an expected household income of $12,387.11, for an individual residing in [redacted], New York.

NYSOH did not fail to issue a timely notice of eligibility determination since the documentation you submitted was insufficient to calculate your eligibility for financial assistance.

Your case has been returned to NYSOH to determine your eligibility for financial assistance and issue an eligibility determination notice.

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।

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 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.

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).