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

Notice of Decision

Decision Date: January 02, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022850

[redacted]

[redacted]

On November 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 17, 2017 disenrollment 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
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Decision

Decision Date: January 02, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000022850

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly disenroll your family from their Medicaid Managed Care plan, effective October 31, 2017?

Procedural History

On November 29, 2016, NYSOH issued a notice of eligibility determination stating you and your family were eligible for Medicaid, effective November 1, 2016. You and your family subsequently enrolled into a Medicaid Managed Care plan.

On September 3, 2017, eligibility for you and your family was systematically redetermined.

On September 17, 2017, NYSOH issued a disenrollment notice stating your family's Medicaid Managed Care plan coverage would end on October 31, 2017, because you were no longer eligible to enroll in the plan.

On September 28, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you and your family were no longer eligible to enroll in a Medicaid plan.

On November 18, 2017, NYSOH issued an eligibility determination stating you and your family were eligible for Medicaid, for a limited time, effective November

1, 2017, until a decision was made on your appeal. Your family was reenrolled into a Medicaid Managed Care plan, effective November 1, 2017.

On November 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 to allow you to submit supporting documents. On November 25, 2017, the Appeals Unit received the requested documentation which was incorporated into the record as Appellant's Exhibit # 1. The record closed thereafter.

Findings of Fact

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

1) You are seeking insurance for yourself, your spouse, and your five children.

2) Your family was determined eligible for Medicaid, effective November 1, 2016, and you were subsequently enrolled into a Medicaid Managed Care plan.

3) According to your account, on September 3, 2017 systematically redetermined your family's eligibility based on information obtained from state and federal data sources.

4) Your account confirms that there was no written notice issued by NYSOH following the September 3, 2017 systematic eligibility redetermination.

5) On September 16, 2017, NYSOH systematically deleted your family's Medicaid Managed Care plan enrollments and instead automatically enrolled you, your spouse, and your oldest two children in an Essential Plan with a $20.00 monthly premium, effective November 1, 2017. Your youngest three children were automatically enrolled into a Child Health Plus plan with no monthly premium.

6) You appealed insofar as your family was no longer eligible to remain in your Medicaid coverage.

7) Your family was granted "Aid to Continue" in your Medicaid Managed Care plan, pending the decision in your appeal, and you were reenrolled, effective November 1, 2017.

8) You testified that you will file your 2017 tax return with a tax filing status of married filing jointly and you will claim five dependents on that tax return.

9) You testified that you work full-time at a rate of $20.69 per hour and that your biweekly paycheck varies with the number of hours you work.

10) You testified that two of your children, [redacted] and [redacted] work part-time, but you were unsure of how much income they would earn in 2017.

11) You testified that no one else in your household earns income.

12) You were directed to submit proof of income for everyone earning income in your household.

13) On November 25, 2017, the Appeals Unit received the following income documentation:

    a. Two biweekly paystubs for you; the most recent with a pay date of November 10, 2017 with year to date gross income of $34,664.14.

    b. Two biweekly paystubs for [redacted] including the paystub for the first paycheck issued on October 27, 2017 showing gross earnings of $172.11. Paystub for pay date of November 10, 2017 showing gross earnings of $346.37 with year to date gross income of $518.48.

    c. Three weekly paystubs for [redacted] the most recent with a pay date of November 16, 2017 showing year to date gross earnings of $7,629.79.

14) You testified you are not sure if you will take a tuition and fees deduction on your 2017 tax return. You were directed to update your application with the relevant information in the event you decide to take such a deduction on your 2017 tax return.

15) You testified that your family resides in Nassau County.

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every 12 months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the

individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

Medicaid Eligibility

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 $37,140.00 for a seven-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).

Medicaid for Children

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 FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1).

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.

Dependent Income

With regard to eligibility for financial assistance through NYSOH, a tax filer's household income includes the MAGI of all the individuals in the taxpayer's household who are required to file a federal tax return for the taxable year (26 CFR § 1.36B-1(e)(1); 42 CFR § 435.603(d)(1)). The MAGI-based income of a child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

A person is not required to file a tax return if their gross income is less than the sum of the exemption amount plus the basic standard deduction allowable for that person (26 USC § 6012(a)(1)(A)). For 2017, a dependent who had yearly gross earned income greater than $6,300.00 or gross unearned income greater than $1,050.00 would be required to file a tax return (*see* IRS Publication 929 as of 8/25/2017).

Legal Analysis

The issue under review is whether NYSOH properly disenrolled your family from their Medicaid Managed care plan, effective October 31, 2017.

Your family was determined eligible for Medicaid, effective November 1, 2016 and subsequently enrolled into a Medicaid Managed Care plan.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual

if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.

According to your account, on September 3, 2017, NYSOH systematically redetermined your family's eligibility based on income information from state and federal data sources.

Although this systematic redetermination was proper and in compliance with the regulations, NYSOH failed to issue the required corresponding annual redetermination notice providing your family's projected eligibility for coverage and financial assistance before changing your family's coverage.

Additionally, NYSOH failed to advise you that you had 30 days to update your account to report any changes or correct any discrepancies in NYSOH's finding. As such, your family was deprived of the opportunity to make changes to your account to potentially prevent disenrollment before NYSOH ended your coverage. Thus, NYSOH's actions were not in compliance with the regulations.

Accordingly, the resulting September 17, 2017 disenrollment notice must be RESCINDED.

The evidence establishes you are in a seven-person household, because you will file your 2017 tax return with a tax filing status of married filing jointly and you will claim your five children as dependents.

It is noted that you submitted documentation including a biweekly paystub for a pay date of November 10, 2017 indicating your year to date gross income was $34,664.14. Based on that information, it is concluded that your average gross biweekly pay through the first 23 pay periods of 2017 was $1,507.14 which amounts to an annual expected income of $39,185.55.

Your dependent [redacted] submitted income documentation including a weekly paystub with a pay date of November 16, 2017 showing year to date gross earnings of $7,629.79. Based on that information, it is concluded that [redacted] average gross weekly pay through the first 45 pay periods of 2017 was $169.55 which amounts to an annual expected income of $8,816.64. Since the evidence establishes that [redacted] will earn more than $6,300.00 in 2017, he is required to file a tax return. Thus, [redacted] expected annual income of $8,816.64 is included in the household income calculation.

It is noted that you also submitted paystubs for your dependent child [redacted]. However, according to that documentation, she only began working in October 2017 and as of November 10, 2017 had only earned $518.48 in gross income. Thus, it is concluded that, based on the documentation submitted, [redacted] will not earn enough income in 2017 to be required to file a tax return. Therefore, [redacted] income is not included in the household income calculation.

Thus, your case is RETURNED to NYSOH to redetermine your family's eligibility based on a household size of seven and the now developed record establishing your expected annual household income for 2017 is $48,002.19.

Decision

The September 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility based on a household size of seven and an annual household income of $48,002.19, with coverage to become effective on such a date so as to avoid any gaps in coverage.

Effective Date of this Decision: January 02, 2018

How this Decision Affects Your Eligibility

Your family should not have been disenrolled from your Medicaid Managed Care plan on October 31, 2017.

This is not a final determination of your family's eligibility.

You will receive an updated eligibility determination notice from NYSOH.

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 September 17, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility based on a household size of seven and an annual household income of $48,002.19, with coverage to become effective on such a date so as to avoid any gaps in coverage.

Your family should not have been disenrolled from your Medicaid Managed Care plan on October 31, 2017.

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 is not a final determination of your family's eligibility.

You will receive an updated eligibility determination notice from NYSOH.

Legal Authority

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A Copy of this Decision Has Been Provided To:

[redacted]

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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.

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 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.

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