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

Notice of Decision

Decision Date: January 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024783

[redacted]

[redacted]

On January 9, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 25, 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).

This page intentionally left blank.

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

Decision

Decision Date: January 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024783

[redacted]

Issue

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

> Did the NY State of Health properly determine that you were not eligible to receive Medicaid through NY State of Health as of November 25, 2017?

Procedural History

On November 24, 2017, you submitted an application for financial assistance with health insurance.

On November 25, 2017, NY State of Health (NYSOH) issued an eligibility determination notice based on the information contained in the November 24, 2017 application, stating that you were not eligible for Medicaid because you have Medicare and are not a child under age 19, age 19 to 20 and living with a parent, pregnant, or a parent caretaker relative of a child younger than 19 years of age. The notice also said that you were ineligible for Medicaid because your income was over the allowable income limit for that program.

On November 25, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination as it related to your ineligibility for Medicaid and enrollment in a Medicaid Managed Care plan through NYSOH.

On January 8, 2018, you faxed 29 pages of documents to NYSOH in support of your appeal.

On January 9, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for 15 days to allow time for the documentation you submitted to become viewable in your NYSOH account. The documentation was viewable on January 10, 2018 and the record was closed that day.

Findings of Fact

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

1) You testified that you expected 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 record reflects that your annual expected gross income is $18,396.00. You testified that this amount consists of $1533.00 per month in Social Security Benefits.

4) You testified that you were found eligible for Medicare around January 2015. The record reflects that your Medicare coverage was effective September 1, 2016.

5) You became eligible for Medicare because you have been certified disabled through the Social Security Administration for at least 24 months.

6) You testified, and the record reflects, that your date of birth is [redacted] and that you are currently [redacted]

7) On July 18, 2017, you submitted a letter to NYSOH stating that you asked that your medical coverage through Medicare (Part B) end. The letter stated that you will still have Medicare Part A (hospital insurance).

8) You testified that the Social Security Administration will not allow you to terminate your Medicare Part A coverage because it is free.

9) You testified that you cannot afford to pay the Medicare Part B premium of $166.00 per month.

10) You testified that you are seeking enrollment through a Medicaid Managed Care plan.

11) You testified that you have applied for Medicaid through your Local Department of Social Services/Human Resources Administration in the past; however, you were denied.

12) Your application states that you live in Bronx County.

13) On January 8, 2018, you faxed in documentation consisting of the following:
    a. a copy of your United States passport
    b. copies of medical bills
    c. a Medicare Part B summary notice
    d. a termination request for your Medicare Part A, dated September 5, 2017
    e. a letter from your landlord confirming your rent amount of $1,100.00
    f. a letter from the Social Security Administration confirming your monthly benefit amount of $1,533.00
    g. a copy of your payments for student loan debt
    h. summary of a doctor's visit and medications taken

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

Applicable Law and Regulations

Medicaid

An individual is eligible for enrollment in Medicaid through NYSOH (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

In general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

- An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
- A pregnant woman or infant,
- A child aged 1-18, or
- A parent or caretaker relative

(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (*see* N.Y. Soc. Serv. Law § 366(1)(c)).

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 $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).

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.

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible to receive Medicaid through NYSOH.

Medicaid through NYSOH (called MAGI-based Medicaid) is available to individuals who meet the financial requirements of Medicaid and are between the ages of 19 and 64, who are not eligible for Medicare Parts A or B; pregnant women or infants; children between the ages of 1 and 18; and parent or caretaker relatives.

According to your testimony and the information in your NYSOH application, you are single with no dependents and, therefore, not a parent or a caretaker relative of a dependent child.

On July 18, 2017, you submitted a letter to NYSOH stating that you asked that your medical coverage through Medicare (Part B) end. The letter stated that you will still have Medicare Part A (hospital insurance). You testified that the Social Security Administration will not allow you to terminate your Medicare Part A coverage because it is free.

Since you are currently eligible for and receiving Medicare Part A coverage through the Social Security Administration, NYSOH properly determined you not eligible for MAGI-based Medicaid based on non-financial requirements.

Furthermore, Medicaid can only 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.

The record reflects that your annual expected gross income is $18,396.00. You testified that this amount consists of $1,533.00 per month in Social Security Benefits. During the hearing, you brought up your living expenses and faxed in copies of medical bills that you have. However, neither of those amounts can be deducted from your modified adjusted gross income when NYSOH determines your eligibility.

On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since $18,396.00 is 152.54% of the 2017 FPL. Therefore, even if you were to meet the non-financial requirements you are over income for MAGI-based Medicaid through NYSOH.

Since you are currently receiving Medicare Part A, and not a parent or caretaker relative, NYSOH properly determined that you are not eligible for Medicaid through NYSOH on a non-financial basis. Furthermore, since your annual household income is over the allowable income limit for Medicaid, you are also not eligible for Medicaid on a financial basis. Therefore, the November 25, 2017 eligibility determination is AFFIRMED.

However, NYSOH does not have the authority to determine whether you qualify for non-MAGI-based Medicaid. That authority lies with the Local Department of Social Services/New York City Human Resources Administration.

Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to the Local Department of Social Services/New York City Human Resources Administration for consideration.

This decision has no effect on your eligibility for Medicaid through your Local Department of Social Services/New York City Human Resources Administration.

Decision

The November 25, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: January 16, 2018

How this Decision Affects Your Eligibility

You do not qualify for MAGI-based Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI Medicaid.

Your case is being referred to your Local Department of Social Services/New York City Human Resources Administration for consideration of your eligibility for non-MAGI-based Medicaid.

This decision has no effect on your ongoing application for Medicaid through your Local Department of Social Services/New York City Human Resources Administration.

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 November 25, 2017 eligibility determination notice is AFFIRMED.

You do not qualify for MAGI-based Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI Medicaid.

Your case is being referred to your Local Department of Social Services/New York City Human Resources Administration for consideration of your eligibility for non-MAGI-based Medicaid.

This decision has no effect on your ongoing application for Medicaid through your Local Department of Social Services/New York City Human Resources Administration.

Legal Authority

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

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)

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).