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

Notice of Decision

Decision Date: April 3, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027796

[redacted]

[redacted]

On March 26, 2018 you appeared by telephone at a hearing on your appeal of NY State of Health's December 12, 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 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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Decision

Decision Date: April 3, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027796

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you were eligible for Medicaid, effective December 1, 2017 to December 31, 2017?

Procedural History

On December 4, 2017 you submitted an application for health insurance.

On December 5, 2017, NYSOH issued a notice stating, in relevant part, that the income information in your application does not match what NY State of Health received from state and federal data sources, and that more information was needed to confirm your eligibility for Medicaid. The notice directed you to provide additional proof of your household income by December 19, 2017, to confirm your eligibility.

On December 11, 2017, you uploaded documentation to your NYSOH account (*see* Document [redacted]). That day, NYSOH reviewed the documentation and determined it was sufficient to verify your household income, and submitted an application on your behalf.

On December 12, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective December 1, 2017.

On December 13, 2017, you updated your application for health insurance.

On December 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for a qualified health plan at full cost, effective January 1, 2018.

Also on December 14, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a qualified health plan beginning January 1, 2018.

Lastly, on January 25, 2018, you contacted NYSOH's Account Review Unit and requested an appeal of the December 12, 2017 eligibility determination notice insofar as you were found eligible for Medicaid for the month of December 2017.

On March 26, 2018, 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 testified that you are seeking to terminate your Medicaid eligibility and enrollment for the month of December 2017 through this appeal.

2) According to the December 4, 2017 application, you attested to an expected annual household income of $9,934.00. You testified that this amount was incorrect.

3) You testified you had trouble completing the application and incorrectly entered your income, which is over the Medicaid limit.

4) You provided documentation that shows that from December 2016 until November 30, 2017, you received $1,675.30 per month in Social Security benefits before any deductions, and that beginning December 1, 2017, your Social Security benefits would be $1,708.70 per month before any deductions (*see* Document [redacted].

5) You testified that your Social Security benefits are your only source of income.

6) According to your NYSOH account, you expect to file your 2018 federal income tax return as single and you will not clam claim any dependents on that tax return.

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

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 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 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 $12,060.00 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). On the date of your application, that was the 2017 FPL, which is $1,005.00 for a one-person household (82 Fed. Reg. 8831).

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 (*id*.).

Medicaid – Continuous Coverage

In the following situations, individuals are not entitled to receive continuous coverage:

- Unable to locate;

- Death;
- Consumer requests to have his/her Medicaid closed;
- Failure to provide or cooperate in obtaining a Social Security Number, if otherwise required;
- Failure to provide documentation of citizenship after the reasonable opportunity period;
- Moved out of State;
- Coverage established under MAGI in error;
- Undocumented pregnant women (only get 60 days post-partum);
- Failure to comply with absent parent (IV-D) requirements; and
- Individuals receiving treatment in a setting where Medicaid eligibility is not available

(*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c); GIS 15 MA/22).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible for Medicaid, effective December 1, 2017.

According to the record, you expect to file your 2018 tax return as single and will not claim any dependents on that tax return. Therefore, you are in a one-person household for purposes of this analysis.

On your December 4, 2017 application, you attested to an expected household income of $9,934.00, and the eligibility determination relied upon that information.

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. On the date of your application, the relevant FPL was $12,060.00 for a one-person household, which at 138% is $16,643.00. Since a household income of $9,934.00 is less than the Medicaid limit of $16,643.00 for a one-person household, NYSOH properly found you to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, you testified the income listed on that application was incorrect. You testified that you had trouble completing the application, incorrectly entered your income, and that your income is higher than the Medicaid limit.

In certain situations, individuals are not entitled to remain in Medicaid, such as when coverage was established under modified adjusted gross income in error.

You provided documentation that shows that from December 2016 until November 30, 2017, you received $1,675.30 per month in Social Security benefits before any deductions, and that beginning December 1, 2017, your Social Security benefits would be $1,708.70 per month before any deductions (*see* Document [redacted]).

Therefore, your 2017 annual household income at the time of your December 11, 2017 application was $20,137.00 (the result of $1,675.30 multiplied by 11, plus $1,708.70), and your monthly income in December 2017 was $1,708.50.

On the date of the December 11, 2017 application, 138% of the FPL for a one-person household seeking Medicaid was $16,643.00 on an annual basis, and $1,378.00 on a monthly basis. Since an annual income of $20,504.40 is more than the maximum allowable annual Medicaid limit, and the monthly income of $1,708.50 is more than the maximum allowable monthly Medicaid limit, the December 12, 2017 eligibility determination notice finding you eligible for Medicaid is not supported by the record and is RESCINDED.

Your case is RETURNED to NYSOH to remove your Medicaid eligibility and enrollment for the month of December 2017, and to notify you accordingly.

Decision

The December 12, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to remove your Medicaid eligibility and enrollment for the month of December 2017, and to notify you accordingly.

Effective Date of this Decision: April 3, 2018

How this Decision Affects Your Eligibility

You were incorrectly found eligible for Medicaid for the month of December 2017.

Your case is being sent back to NYSOH to remove you from Medicaid in the month of December 2017. NYSOH will notify once this is done.

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.

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 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

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Summary

The December 12, 2017 eligibility determination notice is RESCINDED.

You were incorrectly found eligible for Medicaid for the month of December 2017.

Your case is being sent back to NYSOH to remove you from Medicaid in the month of December 2017. NYSOH will notify once this is done.

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 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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