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

Notice of Decision

Decision Date: April 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014731

[redacted]

Dear [redacted],

On April 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 4, 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
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Decision

Decision Date: April 20, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000014731

[redacted]

Issue

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

> Did NY State of Health properly determine that your child was not eligible for Medicaid from November 1, 2016 through November 30, 2016?

Procedural History

On January 3, 2017, you submitted an initial application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills from the last three months for your child. Specifically, you were seeking retroactive Medicaid coverage for the month of November 2016.

On January 4, 2017, NYSOH issued a notice of eligibility determination stating that your child was eligible for Medicaid. This eligibility was effective as of January 1, 2017.

Also on January 4, 2017, NYSOH issued an eligibility determination notice stating that your child was not eligible for Medicaid from November 1, 2016 through November 30, 2016 because the monthly household income of $3,590.00 was over the allowable monthly income limit of $2,056.00 to be eligible for Medicaid.

On January 9, 2016, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as your child was denied retroactive Medicaid for the month of November 2016.

On April 4, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open to April 19, 2017, to allow you to submit supporting documents.

On April 4, 2017, NYSOH received the requested documentation and it was made part of the record as Appellant's Exhibit A. 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 are seeking Medicaid for your child from November 1, 2016 through November 30, 2016, who was [redacted] of age at all times relevant.

2) According to your NYSOH account, you will not be filing taxes this year because the only income you receive is from Social Security Survivor Benefits.

3) You testified that your child resides with you and is your sole dependent.

4) You submitted an application for financial assistance on January 3, 2017. That application states that for the month of November 2016, your income was $3,590.00, which consists of $1,795.00 per month you receive in Social Security benefits and $1,795.00 per month your child receives in Social Security benefits.

5) On April 4, 2017, you faxed in copies of your and your child's Social Security Benefit Statements, which reflect that each of you received $1,795.00 in survivor benefits for the month of November 2016 (*see* Appellant's Exhibit A).

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

Applicable Law and Regulations

<u>Retroactive Medicaid</u>

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the

services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Medicaid for Children

A child aged 19 or 20, whose primary residence is with their parents, 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 federal poverty level (FPL) for the applicable family size (NY Social Services Law § 366)(b)(7); 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).

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 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036).

Survivor Benefits - Adults

"Gross income" is defined as all income from whatever source it is derived from; however, notwithstanding the apparent overall inclusiveness of this definition, there are numerous items that are specifically excluded from gross income (26 USC § 61).

"Adjusted gross income" means, in the case of an individual taxpayer, gross income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of funds from savings accounts, and deductions attributable to royalties (26 USC § 62(a)).

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)).

Survivor Benefits - Children

For the purposes of determining the amount of taxable income a person receives from Social Security benefits, the IRS gives the term “modified adjusted gross income” the same definition as “adjusted gross income,” without regard to certain income that is not relevant here (26 USC § 86(b)(2)). Please note that this definition is different than the definition of MAGI NYSOH uses.

A child’s or tax dependent’s income from Social Security benefits is included in their gross income only to the extent that the sum of the person’s IRS-defined “modified adjusted gross income” and one half of their Social Security benefits is greater than $25,000.00 (26 USC § 86(a)(1), (b)(1)), (c)(1)(A)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child was not eligible for retroactive Medicaid from November 1, 2016 through November 30, 2016.

Your child is in a two-person household for purposes of this analysis. This is because she lives with you and is your sole dependent.

You submitted an application for financial assistance on January 3, 2017 and requested help in paying for your child’s medical bills from November 1, 2016 through November 30, 2016.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual’s initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

You testified that you are seeking Medicaid for your child from November 1, 2016 through November 30, 2016.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in November 2016, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the 2016 monthly FPL of $1,335.00, which is $2,056.00 per month for a two-person household. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during November 2016.

You credibly testified and submitted documentation that reflects that you and your child each receive a monthly Social Security Survivor Benefits in the amount

of $1,795.00, which is a total of $3,590.00. NYSOH relied on that monthly calculated income in reaching its determination.

However, to determine the taxable amount of income a person receives from Social Security benefits, the IRS gives the term “modified adjusted gross income” the same definition as “adjusted gross income.”

You testified that you do not intend to file an income tax return for the 2016 tax year because you only receive income from Social Security Survivor Benefits. Although you may not be required to file a tax return, you are not a child or a tax dependent, so your Social Security Survivors’ income, for purposes of eligibility for financial assistance through NYSOH, is still included in the household’s income. Therefore, your monthly income for November 2016 is $1,795.00.

On the other hand, in cases of children and tax dependents, income from Social Security Benefits is included in their gross income only to the extent that the sum of the person’s IRS-defined “modified adjusted gross income” and one half of their Social Security benefits is greater than $25,000.00. In determining your child’s eligibility for retroactive Medicaid for the month of November 2016, NYSOH included your child’s income as well as your own.

The record reflects that your child received Social Security Survivor Benefits in the monthly amount of $1,795.00 each month in 2016, including November 2016.

Since the record reflects that your child’s only source of income for 2016 is $21,540.00 ($1,795.00 x 12 months) from Social Security Survivor Benefits and one half of that amount ($10,770.00) is less than $25,000.00, your child has no taxable income from Social Security benefits and is not required to file a tax return based on her unearned income. Thus, for purposes of determining your child’s eligibility for Medicaid in the month of November 2016, her income for that month should have been excluded.

Since your monthly household income of $1,795.00 is less than the $2,056.00 monthly allowable Medicaid limit for November 2016, NYSOH improperly determined that your child was not eligible for Medicaid coverage during that month.

Therefore, the January 4, 2017 eligibility determination notice stating that your child was not eligible for Medicaid in the month of November 2016, is incorrect and must be RESCINDED.

Since the record now contains a more accurate representation of what your income was for the month of November 2016, your case is RETURNED to NYSOH to consider your request for your child’s retroactive Medicaid coverage for November 2016 based on a household size of two people and household income of $1,795.00 for the month of November 2016.

Decision

The January 4, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for your child's retroactive Medicaid coverage for November 2016 based on a household size of two and household income of $1,795.00 for the month of November 2016. NYSOH is directed to notify you of its determination.

Effective Date of this Decision: April 20, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your child's eligibility for Medicaid in the month of November 2016.

Your case is sent back to NYSOH to redetermine your child's eligibility based on the evidence you presented at the hearing. NYSOH will notify you of its determination.

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 January 4, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for your child's retroactive Medicaid coverage for November 2016 based on a household size of two and household income of $1,795.00 for the month of November 2016. NYSOH is directed to notify you of its determination.

This is not a final determination of your child's eligibility for Medicaid in the month of November 2016.

Your case is sent back to NYSOH to redetermine your child's eligibility based on the evidence you presented at the hearing. NYSOH will notify you of its determination.

Legal Authority

We are sending you this notice in accordance with 45 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).

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 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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