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

Notice of Decision

Decision Date: August 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018551

[redacted]

Dear [redacted]

On August 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 10, 2016 renewal notice and April 28, 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: August 21, 2017

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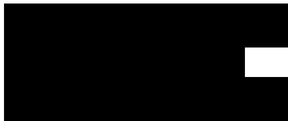

Issues

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

> Did NY State of Health properly determine that you and your child were eligible for Medicaid effective December 1, 2016?
>
> Did NY State of Health properly determine that you and your child were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until November 30, 2017?

Procedural History

On October 10, 2016, NY State of Health (NYSOH) issued a renewal notice stating that, effective December 1, 2016, you and your child were eligible for Medicaid because your household income of between $0 and $22,108.00 was at or below the allowable income limit for this program.

On April 27, 2017, NYSOH received your and your child's updated application for health insurance; specifically, your household income information was updated.

On April 28, 2017, NYSOH issued an eligibility determination notice stating that you and your child were no longer eligible for Medicaid. However, your and your child's Medicaid coverage would continue until November 30, 2017 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of April 1, 2017.

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On May 1, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your enrollment in Medicaid had been continued.

On August 10, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your request to amend your appeal to include your child's enrollment in Medicaid continuous coverage was granted and testimony was received. 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) According to your NYSOH account and your testimony, you filed your 2016 federal income tax return as single and claimed one dependent.

2) According to your NYSOH account, your child is now [redacted] years old.

3) According to your NYSOH account, you elected automatic renewal of your and your child's health coverage for five years.

4) According to the October 10, 2016 application, federal and state data sources showed an annual household income of between $0.00 and $22,108.00. You testified that this income was an accurate reflection of your and your child's net income for the 2016 tax year and that you expect your and your child's household income for 2017 to be about the same.

5) You testified that you are currently self-employed and, after business expense deductions, your household's modified adjusted gross household income is approximately $15,000.00 per year.

6) According to the April 27, 2017 application, you attested to an increased expected gross annual household income of $36,000.00. You testified that this was your gross household income before you deduct your business expenses. You believe your business expenses should be added back into your and your child's household income.

7) You testified that you receive child support payments that you think should be added to your and your child's household income.

8) You testified that you do not want Medicaid for you or your child because you can afford a better insurance program and that your

primary care physician, whom you have seen for many years, does not accept Medicaid as payment.

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

Applicable Law and Regulations

<u>Medicaid for Adults between the Ages of 19 and 65</u>

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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

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).

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 Federal Register 4036).

Generally, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as “continuous coverage” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

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

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)).

Business Expenses Deduction

"Adjusted gross income" is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, deductions that are attributable to a trade or business may be deducted from a taxpayer's adjusted gross income (26 USC § 62 (a)(1)).

Child Support

Generally, payments made for the support of children are not included in the gross income of the parent receiving the payment. It also cannot be deducted by the parent who is making the payments (26 USC § 71(c)(1)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your child were eligible for Medicaid effective December 1, 2016.

According to the October 10, 2016 application, federal and state data sources showed that you and your child had annual household income of between $0.00 and $22,108.00 in 2016. You testified that this income was an accurate reflection of your and your child's net income for the 2016 tax year. NYSOH relied on that information.

During the hearing, you testified that this amount, which is approximately $15,000.00, is your and your child's household income after you deducted your business expenses for the 2016 year. You further testified that your and your

child's gross annual household income does not include the child support you are currently receiving for your child.

You would like your business expense deductions and your child support payments to be added to your net income of $15,000.00 when calculating your and your child's modified adjusted gross annual income.

Since the Internal Revenue Service rules allow certain expenses such as business expenses to be deducted from the calculation of your adjusted gross income, they cannot be added back into your and your child's income when the NYSOH computes your and your child's modified adjusted gross income for financial eligibility purposes. Additionally, child support payments are not included in the gross income of the parent receiving the payment. Therefore, NYSOH correctly determined that your and your child's modified adjusted gross income is between $0.00 and $22,108.00, based on the information received from federal and state data sources.

According to your NYSOH account and your testimony, you filed your 2016 tax return as single and claimed one child as your dependent. Therefore, for purposes of these analyses, you and your child are in a two-person household.

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. Similarly, Medicaid can be provided through NYSOH to children who are one year old and younger than nineteen years old who meet the non-financial requirements and have a household MAGI that is at or below 154% of the FPL for the applicable family size.

On the date of your application, the relevant FPL was $16,020.00 for a two-person household. A two-person household income of $22,108.00 is 138% of the applicable FPL. Since your household income was between $0.00 and $22,108.00, and was at or below 138% of the 2016 FPL, NYSOH properly found you and your child to be eligible for Medicaid on an expected annual income basis, based on the information received from federal and state data sources.

Since the October 10, 2016 eligibility determination notice properly stated that, based on the information from federal and state data sources, you and your child were eligible for Medicaid, it is correct and is AFFIRMED.

The second issue under review is whether NYSOH properly determined that you and your child were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until November 30, 2017.

You testified that at the time of your October 10, 2016 application, NYSOH used your and your child's net household income to determine your eligibility. You

updated your and your child's application on April 27, 2017 to include the gross annual household income you will be receiving before your business expense deductions are subtracted. This update increased your expected 2017 gross annual household income to $36,000.00, which is above the Medicaid limit.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called "continuous coverage."

Credible evidence confirms that you and your child were eligible for Medicaid effective December 1, 2016, and that even though your and your child's 2017 gross estimated annual household income increased when you modified your and your child's income on April 27, 2017, you and your child remained enrolled in Medicaid for the remainder of your 12-month continuous coverage period.

Therefore, the April 27, 2017 eligibility determination notice finding you and your child would have twelve months of continuous coverage through Medicaid was correct and must be AFFIRMED.

Decision

The October 10, 2016 renewal notice is AFFIRMED.

The April 28, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: August 21, 2017

How this Decision Affects Your Eligibility

Your and your child's Medicaid coverage, which began on December 1, 2016, continues until November 30, 2017, barring subsequent qualifying changes that would affect your and your child's eligibility.

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 October 10, 2016 renewal notice is AFFIRMED.

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).

The April 28, 2017 eligibility determination notice is AFFIRMED.

Your and your child's Medicaid coverage, which began on December 1, 2016, continues until November 30, 2017, barring subsequent qualifying changes that would affect your and your child's eligibility.

Legal Authority

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

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.

□□□□□ (Bengali)

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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 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.

(Urdu) اردو

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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