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

Notice of Decision

Decision Date: November 14, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000020760

[redacted]

[redacted]

[redacted],

On October 5, 2017, you both appeared by telephone at a hearing on your appeal of NY State of Health's denial of a request for retroactive Medicaid for your two children for the month of December 2016.

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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Decision

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NY State of Health Account ID: [redacted]
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[redacted]

[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 your children were not eligible for Medicaid for the month of December 2016?

Procedural History

On March 16, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for your family for the three-month period before March 2017.

On March 18, 2017, NYSOH issued an eligibility determination notice stating in relevant part, that your children were eligible for Medicaid effective February 1, 2017.

Also on March 18, 2017, NYSOH issued a notice stating that your request for help with paying medical bills for the three-month period prior to the March 16, 2017 application for your family members had been received. The notice stated in part that proof of household income for the period of December 1, 2016 to January 31, 2017 for your children must be submitted by April 1, 2017.

On March 22, 2017, you uploaded to your account a one page document listing your income and expenses for October 2016, November 2016 and December 2016 [redacted]

On April 1, 2017, April 3, 2017 and April 19, 2017, NYSOH issued notices that the documentation that you submitted did not confirm the information in your application. You were directed to submit additional proof of income for the months of December 2016 and January 2017.

On May 18, 2017, you uploaded to your account bank statements for the months of December 2016 and January 2017. [redacted]

On May 19, 2017, NYSOH issued a notice stating that the documentation that you submitted did not confirm the information in your application. You were directed to submit additional proof of income for your household by June 2, 2017.

On June 22, 2017, you uploaded to your account additional bank statements for the month of December 2016 [redacted]

On July 23, 2017, NYSOH issued a notice stating that, on July 22, 2017, you had requested an appeal regarding the eligibility of two of your children. The reason for the appeal was "Other" and the description of the appeal was "Back Dated."

On October 5, 2017, you and your authorized representative 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 Medicaid from December 1, 2016 to December 31, 2016 for two of your children.

2) According to your NYSOH account, these two children are [redacted] and [redacted].

3) You testified that you have three children and you and your children reside with their father.

4) You testified that you expect to file your 2017 federal income tax return as head of household and will claim one dependent.

5) You testified that the father will claim two children as dependents on his 2017 income tax return.

6) You submitted an application for financial assistance on March 16, 2017, and requested help with paying for medical bills for all your family members for the previous three months.

7) You testified that you are self-employed [redacted] and [redacted]. You testified that you are paid in cash or check after each [redacted].

8) You testified that you have two bank accounts and that you deposit each payment for [redacted] into those accounts, each as a separate transaction and that is how you keep a record of your earnings for tax purposes.

9) According to your testimony and the bank statements you have submitted, you deposited a total of $1,411.00 into your bank accounts in the month of December 2016. You testified that this is an accurate amount of your earnings for that month.

10) According to you NYSOH account and your testimony, your domestic partner receives $690.00 a month in Social Security Disability payments.

11) According to your NYSOH account and your testimony, your three children each receive $152.00 a month in Social Security Survivors benefits.

12) You testified that two of your children had [redacted] in the month of December 2016 and that you are seeking retroactive Medicaid to cover the medical expenses incurred in that month.

13) You testified that you do not plan on taking any deductions on your tax return

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

Applicable Law and Regulations

De Novo Review

NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

Household Composition

In the case where a child is claimed by one parent as a dependent and who is living with both parents who are not filing a joint tax return (42 CFR § 435.603(f)(2)(ii)), the child's family includes the following persons, if living with the child: (1) the child's parents, (2) the child's spouse, (3) the child's children and siblings under the age of 19, or 21 if a full-time student (42 CFR § 435.603(f)(3)).

Modified Adjusted Gross Income (MAGI)

NYSOH bases its eligibility determinations on MAGI as defined in the federal tax code (45 CFR § 155.300(a)). MAGI means the 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.

The MAGI-based income of a child or tax dependent, who is not required to file a tax return, is not included in the 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)(i)). For the 2017 year, a dependent who had yearly gross earned income greater than $6,350.00 or gross unearned income greater than $1,050.00 would be required to file a tax return (see IRS Revenue Procedure 2016-55).

An individual'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)).

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).

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). For the month in which you are requesting retroactive Medicaid coverage, that was the 2016 FPL, which is $28,440.00 for a five-person household (81 Fed. Reg. 4036).

Retroactive Medicaid

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your two children were not eligible for Medicaid from December 1, 2016 through December 31, 2016.

You testified that you are appealing the denial of a retroactive Medicaid for your two children for the month of December 2016. However, the record does not contain a notice of eligibility determination or redetermination on the issue of retroactive coverage for these two children for December 2016.

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid coverage for December 2016 for your two children does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

Your and your authorized representative's credible testimony along with the July 23, 2017 appeal confirmation notice stating that the reason for your appeal was "Other" and the description of the appeal was "Back Dated," permits an inference that NYSOH did deny your request for retroactive Medicaid coverage for your two children for the month of December 2016.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the eligibility determination notice had it been issued.

Medicaid can be provided through NYSOH to children at least one year of age but younger than nineteen if they meet the non-financial criteria and have a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size.

When calculating household size for a child who is living with both parents but only be claimed by one parent as a tax dependent, the household consists of the child, both parents and any siblings under the age of 19. On the date of your March 16, 2017 application, your three children resided with you and your domestic partner. Therefore, following the relationship rule, your children are in a five-person household.

You submitted an application for financial assistance on March 16, 2017 and requested help in paying for medical bills for your family members for the three-month period prior to that application.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether or not that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

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 retroactive Medicaid for the month of December 2016 for two of your children because they had medical services in that month.

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 December 2016, your children would have needed to meet the non-financial criteria and have an income no greater than 154% of the 2016 FPL, which is $3,650.00 per month for a five-person family. There is no indication in the record that your children would have been ineligible for Medicaid based on non-financial criteria during December 2016.

To determine an individual's eligibility for financial assistance, NYSOH must determine a household's MAGI. Generally, a household's MAGI includes the adjusted gross income of all the individuals in that household. However, a child or a dependent's income is not included in the household's MAGI, if they are not required to file a federal income tax return.

A dependent is required to file a tax return in 2017 when their unearned income is greater than $1,050.00. Unearned income includes the taxable portion of Social Security benefits. To determine if any portion of a person's Social Security benefit is taxable, the IRS adds one-half of a person's income from Social Security to any other income that person receives. Any amount more than $25,000.00 is considered taxable income.

At the time of your application, each of your children expected to receive $1,824.00 ($152.00 X 12 months) in Social Security benefits in 2017. One-half of the amount of Social Security benefits that your children expect to receive in 2017 was less than $25,000.00. Therefore, your children are not required to file a tax return based on your Social Security benefits and their unearned income is not included in your household income.

You credibly testified that you are self-employed [redacted] and [redacted]. You testified that you are paid in cash or check after each [redacted]. You testified that you have two bank accounts and that you deposit each payment for [redacted] into those accounts, each as a separate transaction and that is how you keep a record of your earnings for tax purposes. According to your testimony and the bank statements you have submitted, you deposited a total of $1,411.00 into your bank accounts in the month of December 2016. You testified that this is an accurate amount of your earnings for that month. According to your NYSOH account and your testimony, your domestic partner receives $690.00 a month in Social Security Disability payments. As noted above, the monthly Social Security Survivor benefits of $152.00 that each of your three children receive is not included in monthly income. Therefore, the record indicates that in the month of December 2016, you had a monthly household income of $2,101.00.

Since the record now contains a more accurate representation of what your household income was for the month of December 2016, your case is RETURNED to NYSOH to consider your request for retroactive coverage for your two children based on a household size of five people and household income of $2,101.00 for the month of December 2016.

Decision

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your two children for the month of December 2016 based on a household size of five and household income of $2,101.00 for the month of December 2016.

Effective Date of this Decision: November 14, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your two children's eligibility. Your case is sent back to NYSOH to redetermine your children's eligibility based on the evidence you presented at the hearing. NYSOH will inform you of its redetermination.

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

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for your two children for the month of December 2016 based on a household size of five and household income of $2,101.00 for the month of December 2016.

This is not a final determination of your two children's eligibility. Your case is sent back to NYSOH to redetermine your children's eligibility based on the evidence you presented at the hearing. NYSOH will inform you of its redetermination.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

[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)

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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।

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.

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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