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

Notice of Decision

Decision Date: January 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021175

[redacted]

[redacted]

On January 4, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's August 3, 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
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Decision

Decision Date: January 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021175

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly calculate your household's modified adjusted gross income that was used in determining your eligibility for financial assistance?
>
> Did NYSOH properly determine that you were not eligible for Medicaid from July 1, 2017 through July 31, 2017?

Procedural History

On July 20, 2017, you submitted two of your weekly paystubs, dated July 7, 2017 and July 14, 2017 [redacted]

On August 2, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills in July 2017.

On August 1, 2017, you submitted three of your spouse's weekly paystubs, dated July 7, 2017 through July 21, 2017, and your oldest child's (child/child's) weekly paystubs, dated July 14, 2017 and July 21, 2017 (*see* Document [redacted]

On August 3, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with no monthly premium as of September 1, 2017.

Also on August 3, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid from July 1, 2017 through July 31, 2017, because the monthly household income of $3,005.32 was over the allowable monthly income limit of $2,829.00 for Medicaid eligibility.

On August 4, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied you retroactive Medicaid for the month of July 2017.

On January 4, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to January 19, 2018, to allow you time to submit supporting documents.

On January 17, 2018, you submitted a copy of your paystubs, dated July 21, 2017, July 28, 2017, and December 29, 2017. These documents were made part of the record as "Appellant's Exhibit A."

On January 19, 2018, you submitted your spouse's second employer's final 2017 paystub, your child's first employer's paystub, dated August 4, 2017, and your child's second employer paystubs, dated July 13, 2017 and January 11, 2018. These documents were added to the record and marked "Appellant's Exhibit B." The Appeals Unit did not receive any further documents from you and none were viewable in your NYSOH account and the record was closed that same day.

Findings of Fact

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

1) You testified that you are seeking Medicaid for yourself for the month of July 2017.

2) According to your NYSOH account and your testimony, you expect to file your 2017 federal income tax return as married filing jointly and will claim two dependents on that tax return.

3) You submitted an application for financial assistance on August 2, 2017, and requested help paying for medical bills for the past three months.

4) Your application submitted on August 2, 2017, states that for the month of July 2017, your gross household income was $3,005.32, which consisted of $619.52 in income you earned from employment, $1,273.46 in employment income your spouse received, and $1,112.34 in employment income your child received. You testified that you are not sure if this is correct.

5) Your application states that your child, who was [redacted] the time of the application, has an expected annual gross income of $13,348.14. You testified that you believe your child's 2017 gross annual income may be less because she works less hours outside of the summer months.

6) Your submitted documentation shows that you received $643.75 in gross income in July 2017 by adding your four July 2017 paystubs in the amounts of $149.35, $218.51, $165.01 and $120.82. These paystubs show that in 2017 you received a total annual income of $11,100.17 [redacted]

7) Your submitted documentation does not show what your spouse or your child received in gross income in the month of July 2017, or what your child received in gross annual income in 2017.

8) You did not provide your spouse's July 28, 2017 paystub from his first employer, any proof of income for his second employer in July 2017, and your spouse's final 2017 paystub from his first employer. You also did not provide all four of your child's paystubs from her second employer in July 2017, or your child's final 2017 paystubs from both her employers.

9) According to your NYSOH account and your submitted documents, you did not report your spouse's income from his second employer and, as of the August 2, 2017 application, you did not report your child's income from her second employer (*see* Appellant's Exhibit B, p. 1, pp. 3-4).

10) You testified that you are requesting Medicaid for the month of July 2017, because you have medical bills for that month.

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

Applicable Law and Regulations

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)).

With regard to eligibility for financial assistance through NYSOH, a tax filer's household income includes the MAGI of all the individual's in the taxpayer's household who are required to file a federal tax return for the taxable year (26

CFR § 1.46B-1(e)(1); 42 CFR § 435.603(d)(1)). The MAGI-based income of a child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

The IRS determines whether a dependent is required to file an income tax return based on the amount of the dependent's earned and unearned income, marital status, age and whether that dependent is blind. According to the latest final publication, in cases where the dependent is under the age of 65, not blind and earns an income $6,300.00 or higher during the 2016 income tax year (or unearned income in the amount of $1,050 or higher), that dependent is required to file an income tax return for 2016 (IRS Pub. 929).

However, according to the IRS 2017 1040 instructions, a dependent who is under the age of 65, not blind and earns an income $6,350.00 or higher during the 2017 income tax year (or unearned income in the amount of $1,050 or higher) must file a tax return (IRS 2017 1040 instructions Chart B—For Children and Other Dependents).

Unearned income is generally all income other than salaries, wages and other amounts received as pay for work actually performed, including the taxable part of Social Security and pension payments (IRS Pub. 929).

For the purposes of determining a person's eligibility for financial assistance for health insurance through NYSOH, the term "MAGI" 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)).

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 $24,600.00 for a four-person household (82 Fed. Reg. 8831).

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 first issue under review is whether NYSOH properly calculated your household's modified adjusted gross income that was used in determining your eligibility for financial assistance.

Your application submitted on August 2, 2017, states that for the month of July 2017 your gross household income was $3,005.32, which includes income from yourself, your spouse and your child. The eligibility determination relied upon this information.

Household income for the purposes of calculating a person's eligibility for financial assistance to help pay for the costs of health insurance through NYSOH, consists of the modified adjusted gross income of all tax filers in a household who are required to file a tax return. According to the most recent IRS final publication, a dependent is required to file a tax return when their earned income is greater than $6,350.00.

Your application states that your child, who was [redacted] the time of the application, has an expected annual gross income of $13,348.14. You testified that you believe your child's 2017 gross annual income may be less because she works more hours in the summer months. However, you failed to submit sufficient documentation to prove this and, therefore, NYSOH properly included your child's income in your gross monthly household income for July 2017, based on the income information you provided.

You further testified that you were unsure if the July 2017 income attested to in your August 2, 2017 application was correct. You were given the opportunity to provide income documents to prove your household's income that month yet failed to provide sufficient documentation to prove your gross monthly household income. However, you submitted proof of a second job for both your child and your spouse, which you never attested to in your application.

Although, it is reasonable to conclude based on your submitted documentation that your gross household income for the month of July 2017, could be higher than what was attested to in the August 2, 2017 application, for purposes of this analysis, NYSOH properly determined your July 2017 gross monthly household income to be $3,005.32, based on the income information you provided in your application.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid from July 1, 2017 through July 31, 2017.

According to your NYSOH account and your testimony, you expect to file your 2017 federal income tax return as married filing jointly and will claim two dependents on that tax return. Therefore, for purposes of this analysis, you are in a four-person household.

You submitted an application for financial assistance on August 2, 2017, and requested help paying for medical bills for the past three months. You testified that you are seeking your Medicaid coverage retroactively applied solely for the month of July 2017.

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 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.

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 July 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,829.00 per month for a four-person household. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during July 2017.

As stated above, your July 2017 gross household income is $3,005.32, as attested to in your application.

Since your income of $3,005.32 is more than the $2,829.00 monthly Medicaid limit for a four-person household in July 2017, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the

August 3, 2017 eligibility determination notice stating that you were not eligible for Medicaid in the month of July 2017, is correct and is AFFIRMED.

Decision

The August 3, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: January 25, 2018

How this Decision Affects Your Eligibility

You are not eligible for retroactive Medicaid in the month of July 2017.

This Decision does not change your current eligibility.

Your Essential Plan was effective September 1, 2017.

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 August 3, 2017 eligibility determination notice is AFFIRMED.

You are not eligible for retroactive Medicaid in the month of July 2017.

This Decision does not change your current eligibility.

Your Essential Plan was effective September 1, 2017.

Legal Authority

We are issuing this determination 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.

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।

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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 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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