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

Notice of Decision

Decision Date: December 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023102

[redacted]

[redacted]

On December 4, 2017, your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's October 1, 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
Albany, NY 12211

Decision

Decision Date: December 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023102

[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 you were not eligible for Medicaid?

Procedural History

On August 7, 2017, NYSOH issued a renewal notice stating it was time to renew your coverage. The notice stated your Medicaid coverage with [redacted] was ending October 31, 2017 and to update your new NYSOH account.

On September 26, 2017, you submitted an application for financial assistance.

On October 1, 2017, NYSOH issued a notice of eligibility determination based on your last application stating you were eligible to purchase a qualified health plan at full cost, effective November 1, 2017. That notice also stated that you were not eligible for APTC because sources show you were already enrolled in or eligible for minimum value employer sponsored insurance. The notice stated you were not eligible for Medicaid because your income was over the allowable income limit for that program.

On October 4, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as you were not eligible for Medicaid.

On December 4, 2017, your authorized representative appeared on your behalf at a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open up to December 19, 2017, to allow you time to submit supporting documents.

On December 5, 2017, NYSOH's Appeals Unit received your supporting documentation in the form of a 12-page fax. The documentation was incorporated into the record as Appellant's Exhibit 1. The record was closed that day.

Findings of Fact

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

1) You are seeking to be found eligible for Medicaid.

2) Your authorized representative testified you expect to file your 2017 taxes with a tax filing status of head of household.

3) Your September 26, 2017 application states you will only claim one of your children as a dependent on your taxes. Your authorized representative testified this was true.

4) Your authorized representative testified she believes your household should be comprised of both of your children as dependents despite only claiming one as a dependent according to your custody agreement.

5) The custody agreement provided outlines that both parents will have joint legal custody of the children and primary physical placement is shared with alternating weeks.

6) Your authorized representative presented an informational letter dated March 2, 2007 from NYS Department of Health 07 OHIP/INF-1 that states "the household size of a parent with joint physical custody who applies with his or her children includes both the parent and children."

7) Your authorized representative testified there was no divorce decree because you were never married to your spouse.

8) The application that was submitted on September 26, 2017 listed annual household income of $27,021.28, consisting of income you earn from your employment. Your authorized representative testified that this amount was correct.

9) You provided documentation that your monthly income for September 2017 was $3,111.34.

10) Your authorized representative testified you are currently enrolled in her employer sponsored insurance.

11) Your application states that you will not be taking any deductions on your 2017 tax return. Your representative testified she believed this to be accurate.

12) Your application states that you live in [redacted].

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

Applicable Law and Regulations

Medicaid

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 $16,240.00 for a two-person household and $20,420.00 for three-person household (82 Fed. Reg. 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).

"Family size" means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists

of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

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.

Legal Analysis

The issue under review is whether NYSOH properly determined that you were ineligible for Medicaid.

The application that was submitted on September 26, 2017 listed an annual household income of $27,021.28 and the eligibility determination relied upon that information.

The application submitted on September 26, 2017 also stated you will be filing a 2017 tax return as head of household and will only be claiming one of your children as a dependent. Your authorized representative testified this was true and that your children's father will claim one child on his taxes for 2017 per agreed upon terms.

Your authorized representative presented a 2007 NYS Department of Health informational letter which states "the household size of a parent with joint physical custody who applies with his or her children includes both the parent and children." You have joint legal and physical custody with your children's father.

However, effective January 1, 2014, NYSOH has adopted federal regulations which indicate for purposes of Medicaid, the household size of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by

anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents.

Therefore, for purposes of this analysis you are in a two-person household since you are only claiming one of your children as a dependent on your tax return.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $27,021.28 is 166.38% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You submitted copies of your paystubs that shows in September 2017 you received $3,111.34.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,868.00 per month. Since the documentation you provided shows that you earned $3,111.34 in September 2017 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the October 1, 2017 eligibility determination properly stated that, based on the information you provided, you were ineligible for Medicaid it is AFFIRMED.

Decision

The October 1, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: December 8, 2017

How this Decision Affects Your Eligibility

You are ineligible for Medicaid.

If You Disagree with this Decision (Appeal Rights)

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).

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

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- By fax: 1-855-900-5557

Summary

The October 1, 2017 eligibility determination notice is AFFIRMED.

You are ineligible for Medicaid.

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.

বাংলা (Bengali)

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).

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.

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