



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

## Notice of Decision

Decision Date: January 24, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024652

[REDACTED]

[REDACTED]

On January 17, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 7, 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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Albany, NY 12211

## Decision

Decision Date: January 24, 2018

NY State of Health Account [REDACTED]  
Appeal Identification Number: AP000000024652

[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 you were not eligible for Medicaid assistance for July 2017?

## Procedural History

On August 15, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help paying for medical bills for July 2017.

On August 16, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal data sources. The notice directed you to provide documentation of your household income by August 28, 2017.

On August 17, 2017, you uploaded documentation to your NYSOH account.

On August 18, 2017, NYSOH issued a notice stating that the documentation you provided was not sufficient to confirm the information in your application. The notice directed you to submit documentation of your income by August 28, 2017.

On August 24, 2017, you updated your NYSOH account, and again indicated that you were seeking help paying for medical bills for July 2017.

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On August 25, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal data sources. The notice directed you to provide documentation of your household income by September 12, 2017.

On September 7, 2017, you uploaded documentation to your NYSOH account.

On September 8, 2017, NYSOH issued a notice stating that the documentation you provided was not sufficient to confirm the information in your application. The notice directed you to submit documentation of your income by September 27, 2017.

On September 21, 2017, NYSOH uploaded documentation that to your NYSOH account that you faxed to NYSOH on September 7, 2017.

On September 23, 2017, NYSOH issued a notice stating that the documentation you provided was not sufficient to confirm the information in your application. The notice directed you to submit documentation of your income by October 12, 2017.

On October 6, 2017, you uploaded documentation to your NYSOH account.

On October 7, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to \$133.00 per month in advance payments of the premium tax credit, effective November 1, 2017.

Also on October 7, 2017, NYSOH issued a notice stating that you were not eligible for Medicaid assistance for July 2017 because your monthly income of \$3,751.80 was over the allowable monthly income limit of \$1,387.00.

On October 11, 2017, you updated your NYSOH account and indicated that you were looking for help paying for medical bills for the months of August and September 2017.

On October 12, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal data sources. The notice directed you to provide documentation of your household income by October 26, 2017.

On October 17, 2017, you uploaded documentation to your NYSOH account.

On October 18, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective October 1, 2017.

On October 26, 2017, you uploaded additional documentation to your NYSOH account.

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On November 21, 2017, you spoke with NYSOH's Account Review Unit and appealed the October 7, 2017 eligibility determination notice that stated you were not eligible for retroactive Medicaid assistance for the month of July 2017.

On January 17, 2018, you 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 for the month of July 2017.
- 2) You testified that you do not plan to file an individual federal income tax return for 2017.
- 3) You testified that you own a business and that it was incorporated in 2012. You testified that you have not filed an individual income tax return in any year since you incorporated.
- 4) You testified that you are the only person in your household.
- 5) You submitted an updated application for financial assistance on August 15, 2017 in which you requested Medicaid for the month of July 2017.
- 6) Your applications submitted on August 15, 2017 and August 24, 2017 state that your annual expected income for 2017 was \$8,000.00, and that for the month of July 2017, your income was \$666.67.
- 7) You testified that you do not receive a regular income from your corporation, but that you may start doing so in 2018.
- 8) You testified that your personal expenses are paid for with income from the corporation, including expenses like food and clothing.
- 9) You testified that you live at your place of business, so you do not have any personal mortgage or rent expenses.
- 10) You submitted a copy of a 2015 IRS Form 1120, which is a U.S. Corporation Income Tax [REDACTED]).

- 11) You testified that you requested an extension of filing for your 2016 corporate tax return.
- 12) [REDACTED] you submitted a letter dated October 13, 2017 from your tax preparer, [REDACTED] stating that your personal income over the period of June 1, 2017 through September 30, 2017 was \$7,739.84 ([REDACTED]).
- 13) The October 13, 2017 letter also stated the income generated from your restaurant business is used primarily for business expenses, but that a small portion of the income is used to pay for your personal expenses, such as “rent, car payment, and utilities,” and that 4.5% of the business’s total income is used for your personal purposes.
- 14) On October 17, 2017, you uploaded a 60-page spreadsheet showing business expenses and personal expenses for the months of June, July, August, and September 2017. The personal expense categories consist of “personal, personal vehicle, personal utilities, and life insurance” ([REDACTED]).
- 15) In the application submitted on October 11, 2017, you indicated that your annual expected income for 2017 is \$11,000.00 You testified that amount was correct, and that it is based on the amount of income from your business that you utilize for personal expenses.
- 16) You uploaded another letter dated October 26, 2017 from [REDACTED] [REDACTED].” which states that your income was \$896.37 in the month of July 2017, which was arrived at by adding up the amount of business income you utilized for personal expenses in that month ([REDACTED]).

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

## **Applicable Law and Regulations**

### 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 federal poverty

level (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 \$12,060.00 for a one-person household (82 Federal Register 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 issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for July 1, 2017 through July 31, 2017.

You are in a one-person household. You do not expect to file an individual federal income tax return for 2017.

You applied for financial assistance on August 15, 2017, and requested help in paying for medical bills for July 2017.

When an individual file 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.

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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 \$1,387.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during July 2017.

You testified that you own a business, and that this business is incorporated. You submitted a 2015 federal corporate income tax return to NYSOH as proof of your income. You testified that you do not take a regular income from your business, but that your personal expenses are paid out of the corporation's income. You submitted spreadsheets showing business income and expenses for the period of June 2017 through September 2017, as well as a letter from your tax preparer stating that your income in the month of July 2017 was \$896.37.

While it is unclear how NYSOH determined that you had a monthly income of \$3,751.80 in the month of July 2017, there is nevertheless insufficient evidence in the record to justify a finding that you were financially eligible for Medicaid in that month.

The income documentation you submitted consists primarily of information regarding the income of your corporation, and not your personal income. Your tax preparer asserts that your income in the month of July 2017 should be considered \$896.37 because that is the amount that your spreadsheet shows was spent on personal expenses. However, a list of your expenses is not conclusive proof of your income, as it does not preclude the possibility that you received other monies or income from the business during that month. As the documentation you have provided relates to income for a corporation, and not your individual income, it is insufficient for purposes of determining your gross income in the month of July 2017.

Therefore, as there is insufficient information to determine your total income in the month of July 2017, the October 7, 2017 eligibility determination stating that you were not eligible for Medicaid in the month of July 2017, must be AFFIRMED.

## **Decision**

The October 7, 2017 eligibility determination stating that you were not eligible for Medicaid in the month of July 2017 is AFFIRMED.

**Effective Date of this Decision:** January 24, 2018



## **How this Decision Affects Your Eligibility**

There is insufficient basis in the record to find that you were financially eligible for Medicaid in the month of July 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 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).

## **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 7, 2017 eligibility determination stating that you were not eligible for Medicaid in the month of July 2017 is **AFFIRMED**.

There is insufficient basis in the record to find that you were financially eligible for Medicaid in the month of July 2017.

## **Legal Authority**

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

**A Copy of this Decision Has Been Provided To:**



## 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)

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### 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 مجاناً.

### 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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bεtumi ama wo obi a okyerε 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 کرم 1-855-355-5777 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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