



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

Notice of Decision

Decision Date: May 16, 2018

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000029747



Dear [REDACTED],

On May 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 6, 2018 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 at the top of this notice.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 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 Date: May 16, 2018

NY State of Health Number: [REDACTED]
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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 child was eligible for Medicaid, effective March 1, 2018?

Procedural History

On March 5, 2018, you updated your child's application for financial assistance. That day, NYSOH issued a preliminary eligibility determination stating that your child was eligible for Medicaid, effective March 1, 2018.

On March 5, 2018, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination insofar as your child was eligible for Medicaid, and not eligible for Child Health Plus.

On March 6, 2018, NYSOH issued an eligibility determination notice, consistent with the preliminary eligibility determination, stating that your child was eligible for Medicaid, effective March 1, 2018.

Also on March 6, 2018, NYSOH issued a plan enrollment notice confirming in part your child's enrollment in a Medicaid Managed Care plan, effective March 1, 2018.

On May 8, 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.

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Findings of Fact

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

- 1) You testified that you expected to file your 2018 tax return with a tax filing status of Head of Household. You will claim your child as a dependent on that tax return.
- 2) The application that was submitted on March 6, 2018, listed annual household income of \$19,153.00, consisting of \$3,500.00 you received in final payment from your employment and \$15,653.00 in Survivor's benefits.
- 3) You testified that this amount was incorrect because you believed that this amount did not include the correct amount of Survivor's benefits that you expect to receive in 2018.
- 4) You testified that in April 2018, you received your initial Survivor's benefit income in the amount of \$984.00 and expect to receive future checks beginning in May 2018 in the amount of \$1,558.00 per month.
- 5) You testified that your child also receives a Survivor's monthly benefit in the amount of \$1,558.00 per month. Your child will receive this amount each month in 2018.
- 6) At the time of March 5, 2018 application, your child was [REDACTED]
- 7) Your application states that you will not be taking any deductions on your 2018 income tax return.
- 8) According to your NYSOH account and testimony, you and your child live in [REDACTED] NY.
- 9) You testified that you would like your child to be eligible for Child Health Plus, and not Medicaid because he needs to see certain doctors that do not accept Medicaid Managed Care as payment.

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

Applicable Law and Regulations

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

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). On the date of your application, that was the 2018 FPL, which was \$16,460.00 for a two-person household (83 Federal Register 2642).

Child Health Plus

A child who meets the eligibility requirements for Child Health Plus (CHP) may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (New York Public Health Law (PHL) § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be "eligible for medical assistance"; that is, must not be eligible for Medicaid (NY Public Health Law § 2511(2)(b)).

Survivor Benefits - Adults

"Gross income" is defined as all income from whatever source it is derived from; however, notwithstanding the apparent overall inclusiveness of this definition, there are numerous items that are specifically excluded from gross income (26 USC § 61).

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“Adjusted gross income” means, in the case of an individual taxpayer, gross income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of funds from savings accounts, and deductions attributable to royalties (26 USC § 62(a)).

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)).

Survivor Benefits - Children

For the purposes of determining the amount of taxable income a person receives from Social Security benefits, the IRS gives the term “modified adjusted gross income” the same definition as “adjusted gross income,” without regard to certain income that is not relevant here (26 USC § 86(b)(2)). Please note that this definition is different than the definition of MAGI NYSOH uses.

A child’s or tax dependent’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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child was eligible for Medicaid, effective March 1, 2018.

You testified that you expected to file your 2018 tax return with a tax filing status of Head of Household. You will claim your child as a dependent on that tax return. Therefore, for purposes of this analysis, your child is in a two-person household.

The amount of Social Security Survivor’s benefits received by adults is included in MAGI household income in determining household members’ eligibility for financial assistance.

On your March 5, 2018 application, you attested to an expected household income of \$19,153.00, consisting of \$3,500.00 you received in final payment from

your employment and \$15,653.00 in Survivor's benefits. The application also stated that your child is [REDACTED]. NYSOH relied upon this information.

However, in cases of children and tax dependents, 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.

Since record reflects that your child's only source of income for 2018 is \$18,696.00 (\$1,558.00 x 12 months) from Social Security benefits and one half of that amount (\$9,348.00) is less than \$25,000.00, your child has no taxable income from Social Security and is not required to file a tax return based on his unearned income. Thus, for purposes of determining your child's eligibility, NYSOH properly excluded his income and determined your child's household income to be \$19,153.00.

Medicaid can be provided through NYSOH to children between the ages of one and nineteen who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 154% of the FPL for the applicable family size. Since \$19,153.00 is 116.36% of the 2018 FPL of \$16,420.00 for a two-person household, NYSOH properly found your child to be eligible for Medicaid.

You testified that you want your child enrolled in health coverage through Child Health Plus and not Medicaid. However, under New York State's Public Health Law, a Medicaid-eligible child does not qualify to enroll in health insurance through Child Health Plus.

Accordingly, the March 6, 2018 eligibility determination notice stating that your child was eligible for Medicaid is correct and is AFFIRMED.

It is noted that your testimony indicates that your expected Survivor's benefits for 2018 will be less than \$15,653.00. You testified that you expect your 2018 Survivor benefits to be \$11,890.00 because you received your initial Survivor's benefit income in the amount of \$984.00 and expect to receive future checks beginning in May 2018 in the amount of \$1,558.00 per month (\$984.00 + (\$1,550.00 x 7 months)). Since this amount would result in an annual income of \$15,390.00 and an even lower FPL of 0.98%, your child would remain eligible for Medicaid at that lesser amount. Therefore, no further action is required of NYSOH at this time.

Decision

The March 6, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: May 16, 2018

How this Decision Affects Your Eligibility

Your child was properly determined eligible for and remains eligible for Medicaid.

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 March 6, 2018 eligibility determination notice is AFFIRMED.

Your child was properly determined eligible for and remains eligible for Medicaid.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 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)

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 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&tumi ama wo obi a okyerE 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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