



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

Notice of Decision

Decision Date: September 28, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019712

[REDACTED]

Dear [REDACTED],

On September 11, 2017 you appeared by telephone at a hearing on your appeal of NY State of Health's June 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: September 28, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019712

[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 and your newborn were not eligible for Medicaid for March 1, 2017 through March 31, 2017?

Procedural History

On June 6, 2017, you submitted an application for financial assistance with health insurance and indicated that you and your newborn were seeking help paying for medical bills for March 2017.

On June 7, 2017, NYSOH issued a notice of eligibility determination stating that you and your newborn were eligible for Medicaid. This eligibility was effective as of June 1, 2017.

Also on June 7, 2017, NYSOH issued an eligibility determination notice stating that you and your newborn were not eligible for Medicaid for March 1, 2017 through March 31, 2017 because the monthly household income of \$4,600.00 is over the allowable monthly income limit of \$1,868.00 for yourself and of \$3,018.00 for your newborn. This notice further stated that you were eligible for Medicaid from April 1, 2017 through April 30, 2017 and that your newborn was eligible for Medicaid from April 1, 2017 through May 31, 2017.

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On June 12, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as it denied you and your newborn retroactive Medicaid for the month of March 2017.

On September 11, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for fourteen days to allow you time to submit supporting documents. Specifically, the Hearing Officer requested a copy of your March 2017 paystubs, documentation showing when you received your New York State Short Term Disability payments, and a copy of your severance check.

As of close of business on September 25, 2017, no additional documentation was submitted. The record is now closed.

Findings of Fact

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

- 1) You testified that you are seeking Medicaid for yourself and your newborn from March 1, 2017 through March 31, 2017.
- 2) You testified that you expect to file your 2017 federal income tax return as single, and claim one dependent.
- 3) You submitted an application for financial assistance on June 6, 2017.
- 4) Your application submitted on June 6, 2017, states that for the month of March 2017 your income was \$4,600.00.
- 5) You testified that you were out on maternity leave for the month of March 2017.
- 6) You testified that you received a paycheck in March 2017 which represented pay for half of the first week of March 2017.
- 7) You testified that you received two or three weeks of New York State Short Term Disability payments in March 2017, which were \$300.00 before tax.
- 8) You testified, and submitted documentation, that your employer terminated your employment effective [REDACTED].
- 9) You testified that you received a severance check in April 2017.

- 10) You testified that you did not begin receiving unemployment benefits until June 2017.
- 11) You testified that you learned that you were pregnant in August 2016 and gave birth on [REDACTED]
- 12) Your application indicates, and you confirmed, that you and your newborn are [REDACTED] or [REDACTED].
- 13) You testified that your total bills for living expenses are approximately \$1,000.00 per month.
- 14) You testified that you have outstanding bills related to [REDACTED] of your newborn in March 2017.
- 15) Your June 6, 2017 application indicates 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

Household Composition

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid for Pregnant Women

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

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 (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

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(42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Medicaid for Children

A child who is under one year of age 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 223% 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 2017 FPL, which is \$16,240.00 for a two-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)).

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 funds from tax savings accounts, deductions

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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 and your newborn were not eligible for Medicaid for March 1, 2017 through March 31, 2017.

You testified that you expect to file your 2017 tax return with a tax filing status of single and will claim one dependent on your tax return. You testified that on [REDACTED] you gave birth to your newborn. Therefore, the record reflects that in March 2017 you and your newborn were in a two-person household.

You submitted an application for financial assistance on June 6, 2017 and requested help in paying for medical bills for yourself and your newborn for March 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 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 Medicaid for yourself and your spouse from March 1, 2017 to March 31, 2017.

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 March 2017, you and your newborn would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is \$3,018.00 per month. There is no indication in the record that you or your newborn would have been ineligible for Medicaid based on non-financial criteria during March 2017.

The application that you submitted on June 6, 2017 listed your monthly income for March 2017 as \$4,600.00 and the eligibility determination relied upon that information.

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During the hearing, you asked that your current living expenses, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable and phone to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income. Therefore, NYSOH correctly determined your monthly household income to be \$4,600.00 based on the information in your June 6, 2017 application.

Since the monthly income of \$4,600.00 for March 2017 listed in your application was more than the \$3,018.00 monthly Medicaid limit for March 2017, NYSOH properly determined that you and your newborn were ineligible for Medicaid coverage during that month.

During the hearing, you testified that during March 2017 you only received a paycheck for half of the first week of March 2017, as you went on maternity leave, as well as New York State Short Term Disability Benefits. The Hearing Officer left the record open for fourteen days to allow you time to submit documentation of the income you received in March 2017. As of close of business on September 25, 2017, no additional income documentation was submitted. As such, there is insufficient evidence to disturb the June 7, 2017 eligibility determination.

Therefore, the June 7, 2017 eligibility determination stating that you and your newborn were ineligible for Medicaid in the month of March 2017, is correct and is AFFIRMED.

Decision

The June 7, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 28, 2017

How this Decision Affects Your Eligibility

You and your newborn are not eligible for Medicaid in the month of March 2017.

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):

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- 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 June 7, 2017 eligibility determination notice is AFFIRMED.

You and your newborn are not eligible for Medicaid in the month of March 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)

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 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&btumi 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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