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

Notice of Decision

Decision Date: April 05, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014422

[redacted]

Dear [redacted],

On March 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 30, 2016 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.

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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).

STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: April 05, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014422

[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 to receive Medicaid through NY State of Health because you were receiving Medicare?

Procedural History

On December 29, 2016, NY State of Health (NYSOH) received your completed application for health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, stating that you were not eligible to purchase health coverage.

Also on December 29, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to your ineligibility for Medicaid.

On December 30, 2016, NYSOH issued an eligibility determination notice based on the information contained in the December 29, 2016 application, stating that you do not qualify for Medicaid because you were receiving Medicare Public MEC.

On March 28, 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 until April 12, 2017 to allow you time to submit a print out of your unemployment benefits history. On March 31, 2017, the requested

documentation was uploaded to your NYSOH account. The documentation was marked as Appellant's Exhibit 1 and incorporated into the record. The record is now closed.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim one dependent on that tax return.

2) You are seeking insurance for yourself.

3) You testified that you previously received Medicare through the Social Services Administration because of a disability claim.

4) You testified that you lost your Medicare Part B coverage when you began your job in 2013.

5) You testified that you lost your Medicare Part A coverage, which only covered hospitals, in November 2016.

6) On December 21, 2016, you uploaded to your NYSOH account: (1) the first page of your Official Record of Benefit Payment History from the Department of Labor stating that your current unemployment claim was effective August 29, 2016 and that your weekly benefit amount was $430.00, (2) a letter from the Social Security Administration stating that your last month of coverage through Medicare Part B ended October 2013 and (3) a letter from the Social Security Administration that your last month of coverage through Medicare Part A ended November 2016.

7) The December 29, 2016 application for health insurance states that your expected yearly income was $7,310.00.

8) You testified that you lost your job in August 2016 and since that time your income has consisted of benefits received from unemployment.

9) On February 7, 2017, you uploaded a copy of your unemployment benefit monetary benefit determination stating that your weekly benefit rate was $425.00.

10) On March 27, 2017, you uploaded a letter from the Department of Labor stating that your unemployment insurance benefits would run out after your claim for the week of 2/24/2017-3/5/2017.

11) On March 31, 2017, you uploaded a copy of your unemployment benefit payment history to your NYSOH account. This document shows that in the month of December 2016 you received $430.00 in unemployment benefits on December 6, 2016, December 13, 2016, December 20, 2016, and December 28, 2016.

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 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036).

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).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible to receive Medicaid through NYSOH because you were receiving Medicare.

Medicaid through NYSOH (called MAGI-based Medicaid) is available to individuals who are between the ages of 19 and 64, who are not eligible for Medicare Parts A or B; pregnant women or infants; children between the ages of 1 and 18; and parent or caretaker relatives.

You testified that you previously received Medicare through the Social Services Administration because of a disability claim. However, you lost your Medicare Part B coverage when you began your job in 2013 and you lost your Medicare Part A coverage, which only covered hospitals, in November 2016.

On December 21, 2016, you uploaded to your NYSOH account a letter from the Social Security Administration confirming that your last month of coverage through Medicare Part B ended October 2013 and your last month of coverage through Medicare Part A ended November 2016.

Since this letter was provided to NYSOH prior to the December 29, 2016 application, NYSOH incorrectly determined that you were not eligible for Medicaid because you were receiving Medicare Public MEC.

Therefore, the December 30, 2016 determination is RESCINDED.

You testified that you lost your job in August 2016 and since that time your income has consisted of benefits received from unemployment. On March 31, 2017, you uploaded a copy of your unemployment benefit payment history showing that in the month of December 2016 you received $430.00 in unemployment benefits on December 6, 2016, December 13, 2016, December 20, 2016, and December 28, 2016.

Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of December 29, 2016 based on a household of two people, with a monthly income from December 2016 of $1,720.00. NYSOH is directed to make the effective date of any eligibility and/or plan selection effective as if that determination and plan selection was properly made on December 29, 2016.

Decision

The December 30, 2016 determination is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of December 29, 2016 based on a household of two people, with a monthly income from December 2016 of $1,720.00. NYSOH is directed to make the effective date of any eligibility and/or plan selection effective as if that determination and plan selection was properly made on December 29, 2016.

Effective Date of this Decision: April 05, 2017

How this Decision Affects Your Eligibility

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).

NYSOH erred in determining that you were not eligible for Medicaid because you were enrolled in Medicare.

This is not a final decision of your eligibility. Your case is being sent back to NYSOH to redetermine your eligibility as of December 29, 2016.

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 December 30, 2016 determination is RESCINDED.

NYSOH erred in determining that you were not eligible for Medicaid because you were enrolled in Medicare.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of December 29, 2016 based on a household of two people, with a monthly income from December 2016 of $1,720.00. NYSOH is directed to make the effective date of any eligibility and/or plan selection effective as if that determination and plan selection was properly made on December 29, 2016.

This is not a final decision of your eligibility. Your case is being sent back to NYSOH to redetermine your eligibility as of December 29, 2016.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545(a).

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।

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).

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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