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

Notice of Decision

Decision Date: June 05, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015427

[redacted]

Dear [redacted]

On April 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 5, 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 number 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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Decision

Decision Date: June 05, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015427

[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 as of March 1, 2017?

Procedural History

On March 16, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid, effective April 1, 2016.

On January 5, 2017, NY State of Health (NYSOH) issued a renewal notice stating that your coverage could not be renewed for the next coverage year. The notice stated that you no longer qualified for health care coverage through NYSOH and that you could not purchase a health plan at full cost or apply for tax credits or cost sharing reductions or to enroll in Medicaid, the Essential Plan of Child Health Plus, effective March 1, 2017. The notice also stated that you were not eligible for insurance coverage because, based on federal and state data sources, it was determined that you were already enrolled in or eligible for a public insurance program such as Medicare. The notice further stated that NSYOH would send your information to your Local Department of Social Services (LDSS) or Human Resource Administration (HRA) to determine your eligibility for Medicaid on a different basis and your Medicaid coverage would continue until the LDSS/HRA decided your case.

On February 2, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the January 5, 2017 eligibility determination notice as it related to the transfer of your Medicaid Fee-For-Service to the LDSS/HRA.

On April 26, 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 May 11, 2017 to allow you to submit supporting documentation. No documentation was received within the allotted time. The record was closed and this decision is based on record as developed at the time of the hearing.

Findings of Fact

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

1) You testified that you expected to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking insurance for yourself.

3) According to your NYSOH account and your testimony, your date of birth is [redacted] and on [redacted] you were [redacted] You are currently [redacted]

4) You testified that you were found eligible for and enrolled in Medicare Parts A and B in 2005. You became eligible for Medicare because you had been certified disabled through the Social Security Administration for at least 24 months.

5) According to your NYSOH account and your testimony, your Medicare Part B stopped in 2007.

6) According to your NYSOH account and your testimony, you still receive Medicare Part A and are eligible for medical care through the Department of Veterans Affairs.

7) You testified that you recently received a letter from the LDSS/HRA stating that you were not eligible for Medicaid on a different basis.

8) According to your NYSOH account, your case was referred to LDSS/HRA on January 17, 2017 and your Medicaid Fee-For-Service coverage through NYSOH ended on February 28, 2017.

9) According to eMedNY, HRA picked up your Medicaid Fee-For-Service coverage on February 1, 2017 and coverage continued until May 3, 2017.

10) Your application states that you live in Kings County, New York.

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

Applicable Law and Regulations

Medicaid

An individual is eligible for enrollment in Medicaid through NYSOH (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

In general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

- An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
- A pregnant woman or infant,
- A child aged 1-18, or
- A parent or caretaker relative

(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (*see* N.Y. Soc. Serv. Law § 366(1)(c)).

NYSOH is required to refer an individual who is not eligible for MAGI-based Medicaid because they are in receipt of Medicare, certified disabled, or over the age of 65 to the Local Department of Social Services or the Human Resources Administration. During the referral process, an individual's Medicaid eligibility, including their enrollment in a Medicaid Managed Care plan or receipt of Premium Payment Assistance, continues until such a time as their eligibility can be redetermined on a non-MAGI Medicaid basis (*see generally* 42 CFR § 435.1200, 42 CFR § 435.930, 14 OHIP/LCM-2 effective as of December 1, 2014, GIS 16 MA/04 effective as of January 1, 2016).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible to receive Medicaid through NYSOH effective March 1, 2017.

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.

According to your testimony and the information in your NYSOH application, you are single with no dependents and, therefore, you are not a parent or a caretaker relative of a dependent child.

The record reflects that, at the time NYSOH issued the January 6, 2017 eligibility determination notice, you were [redacted]. You testified that you have been certified disabled through the Social Security Administration for at least 24 months.

According to your NYSOH account and your testimony, you are receiving Medicare Part A coverage. Since you are currently receiving Medicare, and not a parent or caretaker relative, NYSOH properly determined that you are not eligible for Medicaid through NYSOH.

However, individuals who are no longer eligible for MAGI-based Medicaid because they are receiving Medicare, over the age of 65 or have become certified disabled may qualify for Medicaid under non-MAGI standards. NYSOH is required to refer these individuals to their Local Department of Social Services (LDSS)/New York City Human Resources Administration (HRA) for redetermination of their Medicaid eligibility.

Once a case is referred, NYSOH and the LDSS/HRA must ensure that an individual's Medicaid is maintained throughout the redetermination process to prevent any gaps in coverage.

The record reflects that NYSOH properly referred your case to HRA on January 17, 2017, and continued your Medicaid Fee-For-Service coverage until February 28, 2017. The eMedNY records indicate that HRA picked up your Medicaid Fee-For-Service coverage effective February 1, 2017 and continued coverage until a decision on your case was made by them on May 3, 2017.

Since the record reflects that NYSOH properly referred your case to your LDSS/HRA and there were no gaps in your Medicaid coverage while your case was being decided by HRA, the January 5, 2017 eligibility determination notice terminating your Medicaid effective March 1, 2017 is AFFIRMED.

According to your testimony, the HRA determined that you were not eligible for Medicaid on a different basis. NYSOH Appeals Unit has no authority to address this issue. You might have recourse through the fair hearing process before the New York State Office of Temporary and Disability Assistance, Office of

Administrative Hearings. You can obtain more information about this process on its website at https://otda.ny.gov/hearings/.

Decision

The January 5, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: June 05, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage through NYSOH ended on February 28, 2017.

Your Medicaid coverage through HRA started on February 1, 2017 and continued until May 3, 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 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 January 5, 2017 eligibility determination is AFFIRMED.

Your Medicaid coverage through NYSOH ended on February 28, 2017.

Your Medicaid coverage through HRA started on February 1, 2017 and continued until May 3, 2017.

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:

[redacted]

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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