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

Notice of Decision

Decision Date: May 25, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015770

[redacted]

Dear [redacted],

On May 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 19, 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 25, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015770

[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 to receive Medicaid through NY State of Health as of February 1, 2017?

Procedural History

On January 15, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective March 1, 2016.

On December 19, 2016, NYSOH issued an eligibility determination notice stating that you are not eligible for Medicaid because, based on information from federal and state data sources, you were already enrolled in or eligible for a public insurance program such as Medicare. Your eligibility ended effective February 1, 2017.

On February 13, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination as it related to your ineligibility for Medicaid.

On May 18, 2017, 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 expected to file your 2017 taxes with a tax filing status of head of household. You will claim one adult dependent on that tax return.

2) You are seeking Medicaid through NYSOH for yourself.

3) According to your account, your date of birth is [redacted] and you are currently [redacted]. Your child, whom you claim as a dependent, was born on [redacted], and is currently [redacted].

4) You testified that you were found eligible for and enrolled in Medicare Parts A and B sometime in 2013 or 2014. You became eligible for Medicare because you have been certified disabled through the Social Security Administration for at least 24 months.

5) According to your NYSOH account, prior to being found ineligible for Medicaid through NYSOH, you were receiving Medicaid Premium Assistance to assist you in paying for your Medicare Part B premium.

6) According to your NYSOH account, on February 17, 2017, you were referred to your Local Department of Social Services regarding the Medicaid Premium Assistance Program.

7) You testified that you have Medicaid through your Local Department of Social Services but that the spend down requirement of $560.00 per month in February 2017 and March 2017 was unaffordable.

8) According to an eMedNY report, dated May 19, 2017, you were granted Medicaid with a spend down requirement effective February 1, 2017, which was subsequently changed to Community Care Medicaid through Ulster County Department of Social Services without any spend down requirement as of April 1, 2017.

9) Your application states that you live in Ulster County, NY.

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).

Medicaid: Parent/Caretaker Relatives

Medicaid can be provided through the Marketplace to parents and other caretaker relatives, regardless of age or receipt of Medicare benefits, whose income is at or below 138% of the FPL of the applicable family size if the dependent child is enrolled in Medicaid, Child Health Plus, or other minimum essential coverage (42 CFR § 435.110(b)-(c); N.Y. Soc. Serv. Law § 366(b); NY Department of Health Administrative Directive 13ADM-03).

A caretaker relative is a relative of a dependent child by blood, adoption, or marriage, who:

- Lives with the dependent child;
- Assumes primary responsibility for the child's care; and
- Is either the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.

(42 CFR § 435.4; N.Y. Soc. Serv. Law § 366(1)(a)(2)(i); NY Department of Health Administrative Directive 13ADM-03)

A dependent child is a child who:

- Is under 18 years old, or is 18 years old and a full-time high school student; and
- Is deprived of parental support by at least parent due to either death, absence, physical or mental incapacity, or unemployment.

(42 CFR § 435.4; N.Y. Soc. Serv. Law § 366(b)(1)(v); NY Department of Health Administrative Directive 13ADM-03)

Legal Analysis

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

Medicaid through NYSOH (known as "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.

The record reflects that, at the time NYSOH issued the December 19, 2016 eligibility determination notice, you were eligible for and enrolled in Medicare Parts A and B as an individual with a certified disability.

As such, you were found ineligible for Medicaid through NYSOH as stated in the December 19, 2016 notice, with eligibility for and coverage in Medicaid through NYSOH continuing until January 31, 2017. Coverage in Medicaid was continued until that date in keeping with the law and state policy until you were transitioned over to Medicaid through your Local Department of Social Services (DSS) in Ulster County, with an effective date of February 1, 2017.

Further, according to your testimony and the information in your NYSOH application, your tax filing status is head of household with one dependent, who is [redacted]. However, because your dependent is [redacted] years old, you do not qualify as a parent or a caretaker relative of a dependent child to be eligible for Medicaid on this basis.

Since you are currently receiving Medicare and not a parent or caretaker relative of a dependent child, NYSOH properly determined that you are not eligible for Medicaid through NYSOH and provided coverage through January 31, 2017, until you transitioned over to Medicaid through Ulster County DSS.

Therefore, NYSOH's December 19, 2016 eligibility determination notice stating that, as of February 1, 2017, you were not eligible for Medicaid because you were already enrolled in or eligible for a public insurance program such as Medicare is correct and AFFIRMED.

According to an eMedNY report, dated May 19, 2017, you were enrolled in Medicaid with a spend down requirement through Ulster County DSS, effective February 1, 2017.

You testified that the spend down requirement from February 2017 through March 2017 was unaffordable. However, NYSOH Appeals Unit does not have jurisdiction over such matters. There is a fair hearing process that you can avail yourself of through NYS Office of Temporary Disability Assistance. To learn more about this process, you can access its websites at *otda.**ny**.gov/oah* *and* *https://otda.**ny**.gov/**hearings**/faq.asp.*

Decision

The December 19, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: May 25, 2017

How this Decision Affects Your Eligibility

You were not eligible for Medicaid through NYSOH as of February 1, 2017.

This decision does not affect your Medicaid coverage with the Ulster County Department of Social Services.

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 19, 2016 eligibility determination notice is AFFIRMED.

You were not eligible for Medicaid through NYSOH as of February 1, 2017.

This decision does not affect your Medicaid coverage with the Ulster County Department of Social Services.

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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