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

Notice of Decision

Decision Date: May 31, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015856

[redacted]

Dear [redacted],

On May 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 17, 2016 eligibility determination and disenrollment notices.

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 31, 2017

NY State of Health Account ID
Appeal Identification Number: AP000000015856

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 NYSOH as of November 30, 2016?

Procedural History

On September 25, 2015, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid, effective as of November 1, 2015.

Also on September 25, 2015, NYSOH issued an enrollment notice confirming, in relevant part, that you were enrolled in a Medicaid Managed Care (MMC) plan.

On June 9, 2016, NYSOH issued a disenrollment notice stating that your enrollment in your MMC plan would end, effective July 31, 2016 because you were no longer eligible to remain enrolled in your current health insurance.

On June 24, 2016, your NYSOH account was systematically updated.

On June 25, 2016, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid, however, your Medicaid coverage would continue until October 31, 2016. Furthermore, the notice stated that you no longer qualified for Medicaid through NYSOH because state and federal data sources showed that you were receiving Medicare and you are not a parent or caretaker relative of a child younger than 19 years of age.

On September 3, 2016, NYSOH issued a notice that it was time to renew your health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not decide whether you would qualify for financial help paying for your health coverage in the upcoming policy period, and that you needed to update your account by October 15, 2016 or you might lose the financial assistance you were currently receiving.

No updates were made to your account by October 15, 2016.

On October 17, 2016, NYSOH issued a disenrollment notice stating that your Medicaid fee-for-service coverage through NYSOH would be discontinued as of November 30, 2016 because you did not renew your coverage and you were no longer eligible to remain enrolled in health insurance through NYSOH.

Also on October 17, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that you did not qualify for Medicaid through NYSOH because state and federal data sources showed that you were receiving Medicare and you are not a parent or caretaker relative of a child younger than 19 years of age.

On February 14, 2017, you updated your NYSOH application.

Also on February 14, 2017, you contacted NYSOH's Account Review Unit and requested an appeal insofar as being determined ineligible for Medicaid.

On February 15, 2017, NYSOH issued an eligibility determination notice stating that you did not qualify for health insurance through NYSOH because you were receiving Medicare Public MEC.

On May 16, 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) According to your NYSOH account and testimony, you are applying for health insurance for yourself.

2) You testified you expect to file your federal income tax return, with the tax status of married filing separately, and do not expect to claim any dependents on that return.

3) You testified that you reside by yourself.

4) You testified that you were enrolled in Medicare Parts A and B, effective May 1, 2016.

5) On August 1, 2016, NYSOH issued a notice stating that you were eligible to receive reimbursement for your Medicare Part B premiums, effective August 1, 2016 (*see* Document [redacted]; uploaded 09/06/2016).

6) You testified that you found out at a dentist's appointment in January 2017 or February 2017 that your Medicaid coverage had been discontinued.

7) According to your NYSOH account and testimony, your income consists of $700.00 monthly in Social Security Disability Insurance benefits and $600.00 monthly pension benefits.

8) You testified that you are seeking to be found eligible for Medicaid.

9) According to your NYSOH account, you reside in Bronx County, New York.

10) You testified that you have not applied for Medicaid through the Human Resources Administration (HRA).

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.

Medicaid through NYSOH (called MAGI-based Medicaid) is available to individuals who are between the [redacted], 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 when NYSOH issued the October 17, 2016 eligibility determination and disenrollment notices, you were eligible for and enrolled in Medicare Parts A and B. Furthermore, the record reflects that you have no dependents and, therefore, are not a parent or a caretaker relative of a dependent child.

Since you were enrolled in Medicare and not a parent or caretaker relative, NYSOH properly determined that you were 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 the New York City Human Resources Administration (HRA) for redetermination of their Medicaid eligibility.

Once a case is referred, NYSOH and HRA must ensure that an individual's Medicaid is maintained throughout the redetermination process to prevent any gaps in coverage. This includes maintaining an individual's Medicaid coverage and their receipt of Medicaid Premium Assistance payments.

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).

Since the record reflects that NYSOH failed to refer your case to your HRA, the October 17, 2016 eligibility determination and disenrollment notices terminating your Medicaid coverage effective November 30, 2016 are RESCINDED

Furthermore, the record supports that you were receiving reimbursement for your Medicare Part B premiums, effective as of August 1, 2016.

Therefore, your case is RETURNED to NYSOH to refer your case to HRA and to reinstate your Medicaid fee-for-service coverage and Medicaid Premium Assistance payments as of December 1, 2016. Furthermore, your coverage and assistance shall continue throughout the redetermination process and until your eligibility for Medicaid on a non-MAGI basis can be properly determined by HRA.

Decision

The October 17, 2016 eligibility determination is RESCINDED.

The October 17, 2016 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to refer your case to HRA and to reinstate your Medicaid fee-for-service coverage and Medicaid Premium Assistance payments as of December 1, 2016 and throughout the transfer and redetermination process.

Effective Date of this Decision: May 31, 2017

How this Decision Affects Your Eligibility

NYSOH is being directed to reinstate your Medicaid fee-for-service coverage and Medicaid Premium Assistance payments as of December 1, 2016

NYSOH is also directed to maintain your Medicaid coverage and Medicaid Premium Assistance payments throughout the redetermination process and until your eligibility for Medicaid on a non-MAGI basis can be properly determined by HRA.

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 October 17, 2016 eligibility determination is RESCINDED.

The October 17, 2016 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to refer your case to HRA and to reinstated your Medicaid fee-for-service coverage and Medicaid Premium Assistance payments as of December 1, 2016 and throughout the transfer and redetermination process.

NYSOH is being directed to reinstate your Medicaid fee-for-service coverage and Medicaid Premium Assistance payments as of December 1, 2016

NYSOH is also directed to maintain your Medicaid coverage and Medicaid Premium Assistance payments throughout the redetermination process and until your eligibility for Medicaid on a non-MAGI basis can be properly determined by HRA.

Legal Authority

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

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).

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)

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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।

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.

(Urdu)اردو

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)

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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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