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

Notice of Decision

Decision Date: August 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016714

[redacted]

Dear [redacted]

On July 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 15, 2017 and February 16, 2017 eligibility determination 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
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Decision

Decision Date: August 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016714

[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 February 14, 2016, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid, effective March 1, 2016.

On May 11, 2016, NYSOH issued a notice stating that you were eligible for reimbursement of Medicare Part B premiums from NYSOH, effective June 1, 2016.

On June 25, 2016, NYOSH issued an enrollment notice stating that you were enrolled in a Medicaid Managed Care plan effective August 1, 2016.

On June 26, 2016, NYSOH issued an eligibility determination notice that stated you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until February 28, 2017 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of August 1, 2016. The notice further stated you no longer qualify for Medicaid through NYSOH because state and federal data sources show that you were receiving Medicare and because you were not a parent or caretaker relative of a child younger than 19 years of age.

On June 26, 2016, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end effective August 1, 2016.

On June 27, 2016, NYSOH issued an enrollment notice stating that you were enrolled in Medicaid and that the type of Medicaid coverage you were eligible for did not require or allow you to enroll in a health plan.

On January 5, 2017, NYSOH issued a notice that it was time to renew your health insurance for the next coverage year. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by February 15, 2017 or you might lose the financial assistance you were currently receiving.

On January 18, 2017, you updated your application for health insurance.

On January 19, 2017, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid, effective February 1, 2017. The notice requested that you submit proof of income for your household by February 2, 2017.

On January 24, 2017, you submitted via facsimile a copy of a December 15, 2016 statement from the Social Security Administration. This document was uploaded to your NYSOH account on February 14, 2017 and verified on that date.

On February 15, 2017 and February 16, 2017, NYSOH issued eligibility determination notices stating that you were no longer eligible for health insurance through NYSOH. The notice stated that you were not eligible for Medicaid, the Essential Plan, advance payments of the premium tax credit and cost sharing reductions or to purchase a qualified health plan at full cost through NYSOH. This was because federal and state data sources show that you were receiving Medicare and individuals enrolled in Medicare cannot receive health coverage through NYSOH. Your eligibility ended effective March 1, 2017. The notice stated that NYSOH would send information to your local Department of Social Services/Human Resources Administration to determine your eligibility for Medicaid on a different basis.

On March 8, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of those eligibility determinations as they related to your ineligibility for Medicaid through NYSOH.

On July 14, 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 single. You will claim no dependents on that tax return.

2) You are seeking Medicaid insurance for yourself.

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

4) Your application states and you testified that you live in [redacted], New York.

5) You testified that you had heart surgery and that you were found eligible for disability benefits through the Social Security Administration and were enrolled in Medicare.

6) You testified that your only source of income is the monthly Social Security benefit payment of $638.20 from which $124.00 is deducted for medical insurance premiums. You submitted a letter in this regard from the Social Security Administration, dated December 15, 2016, by facsimile to NYSOH on January 24, 2017 and this was uploaded to your account on February 2, 2017(*see* Document [redacted]). This document was verified on February 14, 2017.

7) 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. (*see* Document [redacted]).

8) According to your NYSOH account, on February 16, 2017, your information was referred to the New York City Human Resources Administration (HRA) to determine your eligibility for Medicaid on a different basis.

9) You testified that you have been down to the Queens County HRA office but have not received a decision from them as of the date of the hearing.

10) According to an eMedNY report, a database that tracks Medicaid coverage for New York State residents, your Medicaid coverage through NYSOH ended on February 28, 2017 and your Medicaid coverage through Queens County HRA started on March 1, 2017.

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 June 26, 2016 eligibility determination notice, you were eligible for and enrolled in Medicare Parts A and B.

As such, you were found ineligible for Medicaid through NYSOH as stated in the June 26, 2016 notice, with eligibility for and coverage in Medicaid through NYSOH continuing until February 28, 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 [redacted] in [redacted] County, with an effective date of March 1, 2017.

The record reflects that, on January 24, 2017, you submitted a copy of a letter dated December 15, 2016 from the Social Security Administration indicating that you receive $638.20 a month from which $124.00 is deducted for medical insurance premiums. This documenting was uploaded to your NYSOH account on February 2, 2017 and verified by NYSOH on February 14, 2017. As such, the record reflects that you did timely submit proof of your income to NYSOH.

Since you are currently receiving Medicare and receiving Social Security Disability Benefits, and not a parent or caretaker relative, NYSOH properly determined that you are not eligible for Medicaid through NYSOH and provided coverage through February 28, 2017. According to the eMedNY report, your Medicaid coverage through the [redacted] started on March 1, 2017 so there was no gap in coverage in your health insurance.

Therefore, NYSOH's February 15, 2017 eligibility determination notice stating that, as of March 1, 2017, you were not eligible for Medicaid because you were already enrolled in or eligible for a public insurance program such as public assistance or Medicare are correct and AFFIRMED.

Further, the February 16, 2017 eligibility determination notice stating that, you do not qualify for Medicaid, is MODIFIED to state that you do not qualify because

you are already enrolled in or eligible for public insurance program such as Medicare and have Medicaid through New York City HRA, effective March 1, 2017.

Decision

The February 16, 2017 eligibility determination stating that, you do not qualify for Medicaid, is MODIFIED to state that you do not qualify for MAGI-based Medicaid because you are already enrolled in or eligible for public insurance program such as Medicare and have Medicaid through [redacted], effective March 1, 2017.

Effective Date of this Decision: August 23, 2017

How this Decision Affects Your Eligibility

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

This decision does not affect your Medicaid coverage on a different basis with the[redacted].

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 February 16, 2017 eligibility determination stating that, you do not qualify for Medicaid, is MODIFIED to state that you do not qualify for MAGI-based Medicaid because you are already enrolled in or eligible for public insurance program such as Medicare and have Medicaid through New York City HRA, effective March 1, 2017.

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

This decision does not affect your Medicaid coverage on a different basis with the New York City 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.

□□□□□ (Bengali)

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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 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)

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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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