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

Notice of Decision

Decision Date: September 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019448

[redacted]

Dear [redacted],

On August 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 26, 2017 discontinuance 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 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.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: September 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019448

[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 were not eligible for Medicaid through NYSOH?

Procedural History

On September 6, 2016, NYSOH received your application for financial assistance with health insurance. On this application, you indicated that you needed help paying medical bills from the last three months.

On September 7, 2016, NYSOH issued an eligibility determination stating that you were eligible for Medicaid, effective September 1, 2016.

On September 7, 2016, NYSOH issued an eligibility determination stating that you were eligible for Medicaid for August 1, 2016 through August 31, 2016 because you monthly income was allow the monthly income limit for Medicaid.

Also on September 7, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective October 1, 2016.

On May 25, 2017, NYSOH received an updated application for financial assistance with health insurance. This application stated that you were not applying for health insurance through NYSOH because you were “in need of services not available through NYSOH”.

On May 26, 2017, NYSOH issued a discontinuance notice stating that you were no longer eligible for health insurance through NYSOH, effective June 1, 2017. This notice stated that this was because you requested certain Medicaid services that are not available through NYSOH, but these services are only available through your local Department of Social Services. This notice further stated that your Medicaid coverage would continue through your local Department of Social Services.

On June 1, 2017, you spoke to NYSOH's Account Review Unit and appealed the discontinuance notice insofar as you were no longer receiving coverage through NYSOH.

On August 28, 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 are currently receiving Medicaid benefits from your local Department of Social Services.

2) You testified that you do not know why you were transferred to your local office for your Medicaid benefits, and were not able to continue to receive your benefits through NYSOH.

3) You testified that you were unable to receive treatment for one of your chronic conditions when you were transferred because you did not know how to access your Medicaid benefits after they were transferred from NYSOH.

4) You testified that you are seeking compensation for your pain and suffering that you endured after having issues accessing your coverage.

5) Information contained in the system shows that you have had Medicaid coverage through the Local Department of Social Services or [redacted] Human Resources Administration from January 1, 2017 to the present.

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)).

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)).

Appealable Issues

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Legal Analysis

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

You were found eligible for Medicaid through NYSOH as of September 1, 2016 and were subsequently enrolled in a Medicaid Managed Care plan.

On May 25, 2017, NYSOH received an updated application stating that you were not applying for health insurance through NYSOH because you were "in need of services not available through NYSOH".

On May 26, 2017, NYSOH issued a discontinuance notice stating that you were no longer eligible for health insurance through NYSOH because you requested certain Medicaid services that are not available through NYSOH. As a result, you were transferred to your Local Department of Social Services or NYC Human

Resources Administration. Information contained in the system shows that you have had Medicaid coverage through the Local Department of Social Services or NYC Human Resources Administration from January 1, 2017 to the present.

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. A person must also not be enrolled in coverage under the State's Medicaid Plan.

In the present instance, you testified, and the record reflects that you are currently enrolled in Medicaid through your Local Department of Social Services or NYC Human Resources Administration. Since you are enrolled in and receiving Medicaid coverage from another state entity, you are not eligible for Medicaid coverage through NYSOH.

Therefore, the May 26, 2017 discontinuance notice is AFFIRMED.

During the hearing, you testified that you were unsure as to why you got switched to your local [redacted] Human Resources Administration from NYSOH. If you have any questions regarding this transfer or how to access and utilize your Medicaid benefits, you should contact your local [redacted] Human Resources Administration for more information.

You also testified that you filed the appeal because you were looking for NYSOH to compensate you for the pain and suffering you endured as a result of being unable to receive health care treatment while you were unsure how to access your health care benefits after being transferred to your [redacted] Human Resources Administration. This issue relates to monetary damages which is not an issue that the Appeals Unit of NYSOH is authorized to address. Therefore, we must dismiss your appeal, in part, as it pertains to your request for compensation for pain and suffering.

Decision

The May 26, 2017 discontinuance notice is AFFIRMED.

You appeal is DISMISSED, in part, as it pertains to your request for monetary damages for your pain and suffering.

Effective Date of this Decision: September 11, 2017

How this Decision Affects Your Eligibility

You are not eligible for Medicaid through NYSOH, because the record indicates that you have Medicaid through your Local Department of Social Services or NYC Human Resources Administration.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 May 26, 2017 discontinuance notice is AFFIRMED.

You are not eligible for Medicaid through NYSOH, because the record indicates that you have Medicaid through your Local Department of Social Services or NYC Human Resources Administration.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

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)

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).

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.

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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