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

Notice of Decision

Decision Date: October 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019794

[redacted]

Dear [redacted],

On September 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 6, 2017 and June 18, 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 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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: October 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019794

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did the NY State of Health (NYSOH) properly determine that your Medicaid coverage through NYSOH ended as of July 31, 2017?

Procedural History

On July 9, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective August 1, 2016. The July 9, 2016 enrollment notice stated that the type of Medicaid coverage you were eligible for does not require or allow you to enroll in a health plan.

On June 3, 2017, NYSOH issued a notice that it was time to renew your health insurance for the next coverage period. 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 July 15, 2017 or you might lose the financial assistance you were currently receiving.

On June 6, 2017, NYSOH issued an eligibility determination notice, based on your June 5, 2017 updated application, stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until July 31, 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 June 1, 2017. 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 16, 2017, NYSOH received your updated application for health insurance. That day, a preliminary eligibility determination was prepared regarding this last application, stating that you were not eligible to purchase health care coverage through NYSOH.

Also on June 16, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal of the eligibility determinations as they related to your ineligibility for Medicaid through NYSOH.

On June 18, 2017, NYSOH issued an eligibility determination notice, based on your June 16, 2017 updated application, 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, and could not 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.

On July 22, 2017, NYSOH issued an eligibility determination that granted your July 20, 2017 request for aid-to-continue and your coverage under Medicaid Fee-For-Service was restored, effective August 1, 2017, pending the outcome of your appeal.

On September 5, 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 your testimony, 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) You testified that you have been receiving Social Security Disability benefits since December 2012.

4) You testified that you are on Medicare and have a Medicare card.

5) According to your NYSOH account and your testimony, your expected yearly income is $11,148.00 that you receive in Social Security Disability benefits.

6) According to your NYSOH account and your testimony, your date of birth is [redacted], and at the time of the hearing you were [redacted] old.

7) According to your NYSOH account and your testimony, you have a child with a date of birth of [redacted]. Your child turned [redacted] age on [redacted].

8) According to your NYSOH account, on June 16, 2017, you updated your application and removed your child from the account.

9) Your application states that you live in Albany 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 - Parent/Caretaker Relatives

Medicaid can be provided through NYSOH 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 no longer eligible to receive Medicaid through NYSOH as of July 31, 2017.

In the June 6, 2017 eligibility determination notice, you were determined no longer eligible for Medicaid because state and federal data sources showed that you were receiving Medicare and because you are not a parent or caretaker relative of a child younger than 19 years of age.

According to your NYSOH account and your testimony, your daughter turned [redacted] age on [redacted]. Medicaid coverage is available so long as the child of a parent or caretaker relative remains 18 years of age or younger. Since your child turned [redacted] age on [redacted] and since you were receiving Medicare, the June 6, 2017 eligibility determination notice is correct and is AFFIRMED.

In the June 16, 2017 updated application, you removed your child from your NYSOH account. According to your testimony and the information in your June 16, 2017 application, you are single with no dependents and, therefore, you are not a parent or a caretaker relative of a dependent child.

According to your NYSOH account and your testimony, you are [redacted] and are receiving Social Security Disability benefits in the amount of $11,100.00 per year. According to your June 16, 2017 updated application and your testimony, you are enrolled in Medicare.

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.

Since you are currently receiving Medicare, and you are not a parent or caretaker relative, NYSOH properly determined that you are not eligible for

Medicaid through NYSOH. Therefore, the June 18, 2017 eligibility determination notice is correct and is AFFIRMED.

Decision

The June 6, 2017 and June 18, 2017 eligibility determination notices are AFFIRMED.

Effective Date of this Decision: October 5, 2017

How this Decision Affects Your Eligibility

Your eligibility for Medicaid through NYSOH ended July 31, 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 June 6, 2017 and June 18, 2017 eligibility determination notices are AFFIRMED.

Your eligibility for Medicaid through NYSOH ended July 31, 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.

□□□□□ (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).

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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)

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).

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.

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).