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

Notice of Decision

Decision Date: October 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020290

[redacted]

Dear [redacted],

On October 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 4, 2017 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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Decision

Decision Date: October 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020290

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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 no longer eligible to remain enrolled in a Medicaid Managed Care plan as of August 31, 2017, and no longer eligible for Medicaid Fee-For-Service through NYSOH as of September 30, 2017?

Procedural History

On October 14, 2016, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid, effective October 1, 2016.

On November 5, 2016, NYSOH issued an enrollment notice confirming your selection of a Medicaid Manage Care (MMC) plan on November 4, 2016. The notice state that your coverage under this MMC plan would begin effective December 1, 2016.

On July 3, 2017, NYSOH redetermined your eligibility for health insurance.

On July 4, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid; however, your Medicaid Fee-For-Service coverage would continue until September 30, 2017 since certain individuals who qualified for Medicaid get coverage for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of September 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.

Also on July 4, 2017, NYSOH issued a disenrollment notice stating that your coverage in your MMC plan would end effective August 31, 2017.

Finally, on July 4, 2017, NYSOH received (1) a written letter from you requesting an appeal of the termination of your MMC and Medicaid coverage, (2) your 2016 US Individual Income Tax Return (Form 1040), (3) a Statement for Recipients of Certain Government Payments for 2016 (Form 1099-G), (4) a Social Security Benefit Statement for 2016 (Form SSA-1099), and (5) a letter of award issued by the Social Security Administration reflecting your monthly benefit amount.

On August 24, 2017, NYSOH received (1) a Notice of Decision of your Medical Assistance, dated August 19, 2017, issued by Medical Assistance Program confirming Healthfirst as your Medicaid health plan, with such coverage to begin effective September 1, 2017, and (2) an obscured and mostly illegible eMedNY Client Summary reflecting your enrollment details.

On October 4, 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) Your NYSOH account reflects 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) You live in [redacted], New York.

5) You testified that you were found eligible for disability benefits through the Social Security Administration beginning November 1, 2016, and were enrolled in Medicare as of July 1, 2017.

6) You testified, and provided documentation reflecting, that your only source of income is the monthly Social Security benefit payment of $2,700.00.

You testified that a certain amount is now deducted for your enrollment in Medicare.

7) On August 24, 2017, you provided documentation confirming that Human Resource Administration (HRA) determine your eligibility for Medicaid on a different basis, and began your coverage with Healthfirst beginning September 1, 2017.

8) You testified that you never directly contacted HRA, so you were confused as to how your eligibility was determined through that agency.

9) According to your NYSOH enrollment details, your MMC plan coverage was ended through NYSOH on August 31, 2017, and your Medicaid Fee-For-Service coverage was ended through NYSOH on September 30, 2017.

10) You testified that you were seeking for your Medicaid coverage through NYSOH to continue or, in the alternative, clarification as to why you were no longer eligible for that program through NYSOH.

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); NY Social Services 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); 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* NY Social Services 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 no longer eligible to remain enrolled in a MMC plan as of August 31, 2017, and no longer eligible for Medicaid through NYSOH as of September 30, 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 July 4, 2017 eligibility determination notice, you were eligible for and enrolled in Medicare.

As such, you were found ineligible for Medicaid through NYSOH as stated in the July 4, 2017 notice, with eligibility for and coverage in you MMC plan ending effective August 31, 2017, and your Medicaid Fee-For-Service through NYSOH continuing until September 30, 2017.

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 Fee-For-Service coverage through September 30, 2017.

Therefore, NYSOH's July 4, 2017 eligibility determination notice stating that, as of September 30, 2017, you were not eligible for Medicaid Fee-For-Service, and the July 4, 2017 disenrollment confirming your disenrollment from your MMC as of August 31, 2017, because you were already enrolled in or eligible for a public

insurance program such as public assistance or Medicare are correct and AFFIRMED.

Decision

The July 4, 2017 eligibility determination notice is AFFIRMED.

The July 4, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: October 12, 2017

How this Decision Affects Your Eligibility

Your MMC plan coverage through NYSOH ended effective August 31, 2017.

Your Medicaid Fee-For-Service coverage through NYSOH ended effective September 30, 2017.

This decision does not affect your Medicaid coverage on a different basis with the 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 July 4, 2017 eligibility determination notice is AFFIRMED.

The July 4, 2017 disenrollment notice is AFFIRMED.

Your MMC plan coverage through NYSOH ended effective August 31, 2017.

Your Medicaid Fee-For-Service coverage through NYSOH ended effective September 30, 2017.

This decision does not affect your Medicaid coverage on a different basis with the 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:

[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 नि:शुल्क 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.

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).