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

Notice of Decision

Decision Date: November 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020874

[redacted]

Dear [redacted],

On October 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 21, 2017 eligibility determination.

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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Decision

Decision Date: November 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000020874

[redacted]

Issue

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

> Did the NY State of Health properly determine that you were not eligible to receive Medicaid through NY State of Health?

Procedural History

On July 20, 2017, you submitted an application for financial assistance with health insurance.

On July 21, 2017, NY State of Health (NYSOH) issued an eligibility determination notice based on the information contained in the July 20, 2017 application, stating that you were not eligible to receive health coverage through NYSOH because individuals enrolled in Medicare cannot receive health coverage through NYSOH.

On July 26, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination as it related to your ineligibility for health coverage through NYSOH.

On October 13, 2017, you had a scheduled telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You were unable to participate in the hearing at that time and requested an adjournment. The Hearing Officer agreed to adjourn your hearing to October 16, 2017.

On October 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) You testified that you do not plan to file taxes for 2017.

2) You are seeking coverage for yourself.

3) You testified that your annual expected gross income is $8,532.00, consisting of $711.00 per month in social security benefits. You also receive $1,000.00 per month in workers' compensation benefits.

4) You testified that you would like your bills considered with your income, including your rent payment, car insurance bill and phone bill.

5) You testified that you have been eligible for Medicare since 2009. The record reflects that your Medicare coverage was effective as of August 1, 2010.

6) You testified, and the record reflects, that your date of birth is [redacted] and that you are currently [redacted].

7) You testified that you care for your [redacted] grandson while his mother is at [redacted] You also testified that your grandson's father does not provide child support.

8) You testified that your grandson has lived with you since his birth.

9) Your account and application include your daughter, but not your grandson.

10) You testified that you have not applied for Medicaid through your Local Department of Social Services, but that you plan to.

11) Your application states that you live in Suffolk County.

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)).

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 not eligible to receive Medicaid through NYSOH.

In the July 21, 2017 eligibility determination notice, NYSOH determined that you were not eligible for financial assistance through NYSOH because you are currently receiving 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.

According to the information in your NYSOH application, you are single with no dependents and, therefore, not a parent or a caretaker relative of a dependent child.

The record reflects that, at the time NYSOH issued the July 21, 2017 eligibility determination you were [redacted] and receiving Medicare.

Since, according to the information you provided, you are currently receiving Medicare, and not a parent or caretaker relative, NYSOH properly determined that you are not eligible for Medicaid through NYSOH. Therefore, the July 21, 2017 eligibility determination is AFFIRMED.

However, you testified that your [redacted] grandson has lived with you since his birth, and that you provide care for him while his mother is at [redacted]. You further testified that his father does not provide child support. Therefore, you may be considered a legal guardian or caretaker for the purposes of determining your eligibility for Medicaid through NYSOH.

Although your daughter is listed as a member of your household in your account, your grandson is not. You may elect to update your NYSOH application for health insurance to include anyone under the age of eighteen for whom you are a legal guardian or caretaker. As soon as any update is made, NYSOH will then redetermine your eligibility and issue a new notice.

Furthermore, NYSOH does not have the authority to determine whether or not you qualify for non-MAGI-based Medicaid. That authority lies with the Local Department of Social Services.

During the hearing, you testified that you have not applied for non-MAGI-based Medicaid through your Local Department of Social Services. Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to the Local Department of Social Services for consideration.

Decision

The July 21, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to refer your information to your Local Department of Social Services if it has not already done so.

Effective Date of this Decision: November 20, 2017

How this Decision Affects Your Eligibility

NYSOH properly determined that you do not qualify for MAGI-based Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI Medicaid.

Your case is being referred to your Local Department of Social Services for consideration of your eligibility for non-MAGI-based Medicaid.

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 21, 2017 eligibility determination notice is AFFIRMED.

You do not qualify for MAGI-based Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI Medicaid.

Your case is being referred to your Local Department of Social Services for consideration of your eligibility for non-MAGI-based Medicaid.

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 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).

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