



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

Notice of Decision

Decision Date: October 13, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020969

[REDACTED]

Dear [REDACTED],

On October 11, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 1, 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 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: October 13, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020969



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 not eligible for Medicaid?

Procedural History

On July 31, 2017, you submitted an application for health insurance. In response to that application, NYSOH prepared a preliminary eligibility determination stating you were not eligible to purchase health coverage through NYSOH.

Also on July 31, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the July 31, 2017 preliminary eligibility determination insofar as you were not found eligible for Medicaid.

On August 1, 2017, NYSOH issued an eligibility determination notice based on the information contained in the July 31, 2017 application. The notice stated you were not eligible for Medicaid, Child Health Plus, the Essential Plan or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. It also stated that you were not eligible to enroll in a qualified health plan at full cost through NYSOH. This was because, based on the information from federal and state data sources, you were already enrolled in or eligible for a public insurance program such as Medicare. The notice also stated that you are not eligible for Medicaid because your income of \$16,692.00 is over the allowable limit of \$16,643.00.

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On October 11, 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 [REDACTED] of age.
- 2) You testified, and your NYSOH account reflects, that you receive \$1,391.00 per month in Social Security disability benefits.
- 3) You testified that you have been enrolled in, and currently are receiving, Medicare Parts A and B since September 1, 2016.
- 4) You live in [REDACTED], New York.
- 5) You testified that you were seeking Medicaid through NYSOH since you were unable to obtain it through the NYC Human Resources Administration/Department of Social Services (HRA/DSS).
- 6) You testified that you needed to be enrolled in Medicaid through NYSOH since you have been unable to afford the co-pays due in connection with your enrollment with Medicare, and your living expenses in New York City make such co-pays doubly unaffordable.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Medicaid Eligibility

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)).

Medicaid can be provided through NYSOH to adults who meet the following non-financial criteria: (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 that is at or

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below 138% of the federal poverty level (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 NY Social Services Law § 366(1)(c)).

Legal Analysis

The issue is whether NYSOH properly determined that you are not eligible for Medicaid.

To be eligible for MAGI-based Medicaid through NYSOH, a person cannot be entitled to or enrolled in Medicare Part A or B. You testified, and the record reflects that you have been enrolled in Medicare Part A and Part B since September 1, 2016. Therefore, you are not eligible for Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI-based Medicaid. Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to HRA/DSS to determine your eligibility for Medicaid or other Medicare programs.

Decision

The August 1, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: October 13, 2017

How this Decision Affects Your Eligibility

You do not qualify for Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI-based Medicaid. Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to HRA/DSS to determine your eligibility for Medicaid or other Medicare programs.

If You Disagree with this Decision (Appeal Rights)

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).

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

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- By fax: 1-855-900-5557

Summary

The August 1, 2017 eligibility determination notice is AFFIRMED.

You do not qualify for Medicaid through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI-based Medicaid. Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to HRA/DSS to determine your eligibility for Medicaid or other Medicare programs.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

বাংলা (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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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.

אַײַדיש (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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