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

Notice of Decision

Decision Date: January 02, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020973

[redacted]

[redacted]

On December 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 20, 2017 denial of financial assistance 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: January 02, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020973

[redacted]

Issue

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

> Did NY State of Health properly determine that you were not eligible to receive Medicaid through NY State of Health as of your June 19, 2017 application?

Procedural History

On May 8, 2017, NY State of Health (NYSOH) issued notice stating that you and/or members of your household needed to renew your health insurance coverage through NYSOH. This notice further stated that you had Medicaid coverage through your local Department of Social Services until July 31, 2017. This notice directed you to update the information in your NYSOH between June 16, 2017 and July 15, 2017, before your Medicaid coverage ends in order to renew your coverage.

On June 19, 2017, NYSOH received an updated application for financial assistance with health insurance.

On June 20, 2017, NYSOH issued a denial notice stating that you do not qualify for health insurance through NYSOH and did not qualify for Medicaid through NYSOH because you are 65 years of age or older, or state and federal data sources show that you are receiving Medicare and you are not a parent or caretaker relative of a child younger than 19 years of age.

On August 1, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to your ineligibility for Medicaid.

On December 21, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open to allow for the Hearing Officer to listen to the telephone record from NYSOH's Call Center from June 19, 2017.

The Hearing Officer listened to the available telephone recording from June 19, 2017, after which the record was closed.

Findings of Fact

A review of the record supports the following findings of fact:

1) According to your NYSOH account, you were transferred to NYSOH from your local Department of Social Services.

2) According to your NYSOH account, you had Medicaid coverage through your local Department of Social Services until July 31, 2017.

3) Your application states that you do not intend on filing a tax return.

4) You are seeking health insurance for yourself.

5) You testified that you reside with your [redacted] child, and that you are your child's primary caregiver.

6) You testified that you are eligible and enrolled in Medicare. You became eligible for Medicare because you have been certified disabled through the Social Security Administration for at least 24 months.

7) According to your NYSOH account, you have been enrolled in Medicare coverage since August 1, 2016.

8) Your application states that your annual expected household income is $15,600.00, which consists of your Social Security Disability benefits. You testified that this amount is correct.

9) Your application states that you live in Monroe County, New York.

10) NYSOH's Appeals Unit reviewed the recorded telephone call you made to NYSOH on June 19, 2017, and determined that:

a. You were calling that day to transition your health insurance coverage from your local Department of Social Services to NYSOH;
b. The NYSOH representative asked if you were the only one on the application and you answered yes to this question;
c. When the NYSOH representative inquired about your income, you informed him that you daughter also had income; and
d. The NYSOH representative informed you that he was not concerned about your daughter's income because you were the only one on the application.

11) You testified that you are looking to be found eligible for Medicaid coverage 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); 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)).

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)

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible to receive Medicaid through NYSOH as of your June 19, 2017 application.

On May 8, 2017, NYSOH issued a notice stating that you needed to renew your coverage for health insurance through NYSOH. This notice stated that you had Medicaid coverage through your local Department of Social Services until July 31, 2017, and that in order for your coverage to continue you needed to update your information in your NYSOH account between June 16, 2017 and July 15, 2017. On June 19, 2017, you updated your NYSOH account and you were determined to be ineligible to receive health insurance coverage through NYSOH.

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. As a result, a person who is eligible for Medicare can be found eligible for MAGI-based Medicaid if they are determined to be a parent or caretaker relative of a dependent child.

You testified, and your NYSOH account indicates, that you are eligible for Medicare. However, you testified that you are the parent and primary caretaker of your [redacted] child, who lives with you. A review of the telephone call from June 19, 2017 indicates that you informed the NYSOH representative that your

child had income and he stated that he was not concerned about your child since you were the only one on the application.

Based on the credible evidence of record, it is reasonable to conclude that had the NYSOH representative inquired more about your child during the initial application process on June 19, 2017, your minor child would have been added to your NYSOH account. Had your child been added to your NYSOH account, you may have been found eligible for health insurance coverage through NYSOH. Since the fact that your minor child was not added to your account on June 19, 2017, was due to an error made by NYSOH, the June 20, 2017 denial of financial assistance notice is RESCINDED.

Your case is RETURNED to NYSOH to contact you in order to update your NYSOH account to include your minor child. Once your minor child has been added to your NYSOH account, NYSOH is directed to redetermine your eligibility as of June 19, 2017, using the information in your updated application.

Decision

The June 20, 2017 denial of financial assistance notice is RESCINDED.

Your case is RETURNED to NYSOH to contact you in order to update your NYSOH account to include your minor child. Once your minor child has been added to your NYSOH account, NYSOH is directed to redetermine your eligibility as of June 19, 2017, using the information in your updated application, and to notify you accordingly.

Effective Date of this Decision: January 02, 2018

How this Decision Affects Your Eligibility

This is not a final determination on your case.

Your case is being sent back to NYSOH to redetermine your eligibility, as of June 19, 2017, once your child has been added to your NYSOH account. NYSOH will notify you of its redetermination.

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.

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).

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

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Summary

The June 20, 2017 denial of financial assistance notice is RESCINDED.

Your case is RETURNED to NYSOH to contact you in order to update your NYSOH account to include your minor child. Once your minor child has been added to your NYSOH account, NYSOH is directed to redetermine your eligibility as of June 19, 2017, using the information in your updated application, and to notify you accordingly.

This is not a final determination on your case.

Your case is being sent back to NYSOH to redetermine your eligibility, as of June 19, 2017, once your child has been added to your NYSOH account. NYSOH will notify you of its redetermination.

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:

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.

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