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

Notice of Decision

Decision Date: November 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021975

[redacted]

[redacted]

On November 2, 2017, you appeared by telephone, along with your Authorized Representative, at a hearing on your appeal of NY State of Health's August 2, 2017 eligibility determination 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: November 13, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000021975

[redacted]

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 financial assistance, and specifically not eligible for Medicaid, because you did not agree to cooperate with the Child Support Enforcement Unit (CSEU)?

Procedural History

On August 1, 2017, you updated your application for financial assistance through NYSOH. In that application, you answered "No" to the question, "[redacted] agree to cooperate with the CSEU?"

On August 2, 2017, NYSOH issued a notice of eligibility determination stating that you were newly eligible to enroll in a qualified health plan at full cost, effective September 1, 2017. The notice also stated that you were not eligible for Medicaid because you did not agree to cooperate with the CSEU. It further stated that you were not eligible for the Essential Plan, Child Health Plus, or tax credits to help pay for your coverage because individuals do not qualify for help paying for coverage if they do not comply with the requirements for obtaining Medicaid.

On August 30, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal of that eligibility determination, insofar as you were not eligible for Medicaid. You also requested Aid to Continue, pending the outcome of your appeal.

On September 15, 2017, NYSOH issue a notice of eligibility determination stating that you were eligible for Medicaid for a limited time, effective September 1, 2017. This was because your request for Aid to Continue was granted, pending the outcome of your appeal.

Also on September 15, 2017, NYSOH issue a notice of enrollment confirmation, confirming your enrollment in an MMC plan, beginning September 1, 2017. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On November 2, 2017, you had a hearing with a Hearing Officer from the NYSOH Appeals Unit. During the hearing, [redacted], acted as your Authorized Representative (AR). The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) Your NYSOH account reflects that you first applied for coverage through NYSOH in January 2015, and that you began to receive Medicaid through NYSOH at that time.

2) Your NYSOH account reflects that you have three children: [redacted].

3) Your NYSOH account reflects that your August 1, 2017 application was the first time that you answered “No” to the question regarding whether you would cooperate with CSEU.

4) You testified that you have never been asked this question before until this application, which you completed with a representative from Fidelis.

5) Your NYSOH account reflects that your expected annual income is $7,020.00. You testified during the hearing that you are now receiving additional rental income of $455.00 per month.

6) During the hearing, your AR stated that [redacted].

7) Your AR stated that you are willing to provide information to NYSOH about him, and that he will also provide information about himself if NYSOH wants it, but that you will not pursue him for child support, and you will not agree to assign your right to pursue him for support to the CSEU.

8) Your AR stated that you are under the treatment of [redacted] and [redacted], and suffer from [redacted] and [redacted] about [redacted].

9) Your AR stated several times that, if you were forced to pursue him for support, it would cause [redacted]."

10) Your AR state that involving the family courts in a household puts stress on the household, and that you will not agree to allow the CSEU to act on your behalf to pursue him for support.

11) You testified that, after you were asked the question about whether you would comply and answered that you would not, you were not asked any further questions.

12) Your NYSOH account does not contain any indication that NYSOH made any effort to ascertain whether you had good cause for not complying with the requirement to cooperate with CSEU.

13) Your NYSOH account does reflect that you uploaded documentation in support of your claim that you have good cause not to comply, [redacted]).

14) You testified that you were given a number to call regarding your good cause claim, but when you called that number, the people who answered said they only dealt with good cause for changing your insurance plan.

15) Your AR stated that you need your Medicaid coverage because it is important that you receive your medication from your [redacted] providers.

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

Applicable Law and Regulations

Medicaid

Medicaid can be provided through NYSOH to adults who: (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 (MAGI) that is at or below 138% of the 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)).

Under both federal and state law, parents who apply for Medicaid on behalf of themselves and their children must cooperate with the CSEU to establish paternity and obtain medical support from the absent parent (42 CFR § 433.145; 18 NYCRR § 360-3.2(c)). However, the applicant may not be required to comply if the applicant establishes good cause for an exemption from that requirement (42 CFR § 433.147; 18 NYCRR § 360-3.2(f)).

Good cause can include a fear of physical or emotional harm to the parent and/or children as a result of cooperating with establishing paternity or securing support (18 NYCRR § 360-3.2(f)(iv)). The threat of emotional harm to the parent or caretaker relative must be such that, if the parent cooperated with establishing paternity or pursuing support, the parent's capacity to adequately care for the child/children would be reduced (18 NYCRR § 360-3.2(f)(iv)-(vi)).

When an individual asserts a good cause claim, the individual must provide evidence to corroborate the claim. The evidence must be reviewed, and, if necessary, the individual should be contacted if additional corroborative evidence is needed. A final determination of whether good cause exists must be made in writing, and must state the findings and basis for the determination that good cause does, or does not, exist (18 NYCRR § 360-3.2(f)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you are not eligible for Medicaid or other financial assistance through NYSOH, because you refused to cooperate with the CSEU.

An applicant for Medicaid who is applying on behalf of themselves and their children must cooperate with the CSEU to establish paternity and obtain support from an absent parent. However, an applicant may assert a good cause claim for the refusal to cooperate.

You submitted an application for financial assistance on behalf of yourself and your three children on August 1, 2017. In that application, you indicated that you would not cooperate with the CSEU to pursue their father for support. As a result, your children were found eligible for Medicaid, but you were found ineligible for financial assistance because you refused to cooperate with the CSEU.

During the hearing, your AR, who is the father of your children, stated that you did not want to assign the right to pursue him for support to the CSEU because it could have a negative impact on the [redacted]

Your NYSOH account reflects that you uploaded documentation in support of your claim that you have good cause not to comply with the CSEU. Your NYSOH account contains no indication that anyone from NYSOH reviewed this documentation, spoke to you about your good cause claim, or otherwise considered whether your claim had merit.

If an individual claims good cause for failing to comply with the CSEU, the individual must provide corroborative evidence. That evidence must then be examined, and the individual must be given a decision in writing as to why their good cause claim is, or is not, approved.

Because your NYSOH account is void of any notes or other indication that NYSOH considered your claim of good cause, NYSOH failed to properly address your claim before finding you ineligible for Medicaid.

Therefore, your case is RETURNED to NYSOH to consider your good cause claim, and to issue a determination as to whether you are found to have good cause for refusing to comply with the CSEU, including the specific findings on which that determination is based.

NYSOH will contact you if it needs more information to assess your good cause claim.

Decision

Your case is RETURNED to NYSOH so that NYSOH may consider your good cause claim and issue a determination in writing as to whether good cause exists for your refusal to cooperate with the CSEU, including the specific factors on which NYSOH has based its determination.

Effective Date of this Decision: November 13, 2017

How this Decision Affects Your Eligibility

NYSOH failed to adequately address your claim that you have good cause for refusing to cooperate with the CSEU.

Your case is being sent back so that NYSOH can determine whether good cause exists. NYSOH will notify you in writing of its determination.

NYSOH will contact you if more information is needed to assess your good cause claim.

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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

Your case is RETURNED to NYSOH so that NYSOH may consider your good cause claim and issue a determination in writing as to whether good cause exists for your refusal to cooperate with the CSEU, including the specific factors on which NYSOH has based its determination.

NYSOH failed to adequately address your claim that you have good cause for refusing to cooperate with the CSEU.

Your case is being sent back so that NYSOH can determine whether good cause exists. NYSOH will notify you in writing of its determination.

NYSOH will contact you if more information is needed to assess your good cause claim.

Legal Authority

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

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)

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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)

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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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