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

Notice of Decision

Decision Date: December 4, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022925

[redacted]

[redacted]

On November 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 29, 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 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: December 4, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022925

[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 September 30, 2017?

Procedural History

On October 24, 2015, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid, effective December 1, 2015. You were enrolled in a Medicaid Managed Care plan effective December 1, 2015.

On February 2, 2017, NYSOH issued a disenrollment notice stating that your Medicaid Managed Care plan would end March 31, 2017. The notice stated this was because records show you have other health insurance or Medicare. Individuals who have health insurance or Medicare cannot be enrolled in a Medicaid Managed Care plan. The notice stated you still have Medicaid coverage, but the way you get your services have changed.

On February 2, 2017, NYSOH issued an eligibility determination notice stating you are no longer eligible for Medicaid, but your coverage would continue until September 30, 2017. The notice stated this was because certain individuals who qualified for Medicaid get coverage for twelve continuous months from the date they were last determined. The notice stated you no longer qualify for Medicaid because state and federal data sources show you are receiving Medicare and are not a parent or caretaker relative of a child younger than 19.

On September 22, 2017, NYSOH issued a notice stating you were ineligible for health coverage through NYSOH. The notice stated you were no longer eligible for Medicaid because your household income of $32,800.00 was over the allowable income limit of $16,643.00, and based on information from state and federal data sources, it was determined you were already enrolled in or eligible for a public insurance program such as Medicare. The notice stated your information was sent to your Local Department of Social Services on September 16, 2017.

On September 28, 2017, NYSOH received your updated application for health insurance. That day a preliminary eligibility determination was prepared stating that you were not eligible to purchase health coverage through NYSOH.

Also on September 28, 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 September 29, 2017, NYSOH issued an eligibility determination notice, based on your September 28, 2017 application, stating that you are not eligible for Medicaid because based on information from federal and state data sources, you were already enrolled in or eligible for a public insurance program such as Medicare.

On November 8, 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 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 insurance for yourself.

3) You testified that you were found eligible for Social Security Disability in 2014 and have been [redacted].

4) You testified you were not sure if you were eligible for and enrolled in Medicare Parts A and B. You testified you thought you had a card stating this but you did not have it available.

5) NYSOH data sources show you are eligible for and enrolled in Medicare Part A and B.

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

7) You testified that you have not applied for Medicaid through your Local [redacted], and have not received any information regarding your case being transferred to that office.

8) The record reflects that you did not request and were not granted Aid to Continue.

9) The record reflects that prior to being found ineligible for Medicaid through NYSOH, you were receiving Medicaid Premium Assistance to assist you in paying for your Medicare Part B premium effective April 1, 2017.

10) Your application states that you live in [redacted]

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)).

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 not eligible to receive 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 September 29, 2017 eligibility determination you were [redacted] You testified you were not sure if you were eligible for and enrolled in Medicare Parts A and B. However, NYSOH data sources show you are eligible for and enrolled in Medicare Part A and B.

Since you are currently receiving Medicare based on data sources, and not a parent or caretaker relative, NYSOH properly determined that you are not eligible for Medicaid through NYSOH.

However, individuals who are no longer eligible for MAGI-based Medicaid because they are receiving Medicare, over the age of 65 or have become certified disabled may qualify for Medicaid under non-MAGI standards. NYSOH is required to refer these individuals to their Local Department of Social Services (LDSS)/New York City Human Resources Administration (HRA) for redetermination of their Medicaid eligibility.

Once a case is referred, NYSOH and the LDSS must ensure that an individual's Medicaid is maintained throughout the redetermination process to prevent any gaps in coverage. This includes maintaining an individual's coverage through

their Medicaid Managed Care plan or their receipt of Medicaid Premium Assistance payments.

Since the record reflects that NYSOH referred your case to the Local Department of Social Services on September 16, 2017, but ended your Medicaid Premium Assistance program and Fee for Service enrollment as September 30, 2017 before your case was completely transferred to LDSS the September 29, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to refer your case to Suffolk County LDSS. NYSOH is directed to reinstate your Medicaid and Medicaid Premium Assistance payments as of October 1, 2017 and to continue your coverage until your case can be properly transferred to Suffolk County LDSS for a redetermination of your eligibility for Medicaid on a non-MAGI basis.

Decision

The September 29, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to refer your case to Suffolk County LDSS.

NYSOH is directed to reinstate your Medicaid and Medicaid Premium Assistance payments as of October 1, 2017 and to continue your coverage until your case can be properly transferred to Suffolk County LDSS for a redetermination of your eligibility for Medicaid on a non-MAGI basis.

Effective Date of this Decision: December 4, 2017

How this Decision Affects Your Eligibility

Your case is being referred to [redacted] for consideration of your eligibility for non-MAGI-based Medicaid.

Your Medicaid coverage is reinstated as of October 1, 2017 and will continue until a redetermination of your eligibility can be made.

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 September 29, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to refer your case to Suffolk County LDSS.

NYSOH is directed to reinstate your Medicaid and Medicaid Premium Assistance payments as of October 1, 2017 and to continue your coverage until your case can be properly transferred to Suffolk County LDSS for a redetermination of your eligibility for Medicaid on a non-MAGI basis.

Your case is being referred to [redacted] for consideration of your eligibility for non-MAGI-based Medicaid.

Your Medicaid coverage is reinstated as of October 1, 2017 and will continue until a redetermination of your eligibility can be made.

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)

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).

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।

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)

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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