



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

Notice of Decision

Decision Date: March 20, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025771

[REDACTED]

Dear [REDACTED],

On February 16, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 14, 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 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: March 20, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025771



Issue

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

Did NY State of Health(NYSOH) properly determine your child was eligible to enroll in a full cost qualified health plan and not eligible for Medicaid, effective January 1, 2018?

Procedural History

On December 13, 2017, an application for financial assistance with health insurance was submitted on behalf of your child. That day a preliminary eligibility determination was prepared stating your child was eligible to enroll in a full cost qualified health plan.

Also on December 13, 2017, you contacted NYSOH's Account Review Unit and requested an appeal insofar as your child was not eligible for Medicaid.

On December 14, 2017, NYSOH issued an eligibility determination notice stating your child was eligible to enroll in a qualified health plan, at full cost, effective January 1, 2018. The notice indicated that your child was not eligible for Child Health Plus or Medicaid, because state and federal data bases showed she was already enrolled in Medicaid, Child Health Plus, or another program.

On December 16, 2017, NYSOH issued an enrollment notice, based on your December 15, 2017 plan section, confirming your child was enrolled in a full cost qualified health plan, effective January 1, 2018.

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On February 16, 2018, 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 are seeking Medicaid through NYSOH for your child.
- 2) According to your account, your child was enrolled in a Medicaid Managed Care plan through NYSOH for a period in 2015.
- 3) She was subsequently disenrolled, December 31, 2015, and determined ineligible for Medicaid based on information from state and federal data bases showing she was enrolled in Medicaid through your local department of social services (LDSS).
- 4) On January 13, 2016, your application was updated to indicate your child was no longer applying for health coverage through NYSOH.
- 5) On December 13, 2017, your account was updated to indicate your child was applying for health coverage through NYSOH and an application was submitted on her behalf that day listing your annual expected household income as \$17,940.00.
- 6) Your child was determined eligible to purchase a full cost qualified health plan, effective January 1, 2018.
- 7) Your child was not eligible for Medicaid, because data sources indicates she was actively enrolled in Medicaid through your LDSS since March 2015.
- 8) You testified that your child was currently enrolled in Medicaid through your LDSS.
- 9) You testified that your child had been certified disabled approximately [REDACTED] and began receiving Social Security disability benefits.
- 10) You testified that once your child began receiving the Social Security disability benefits, she was automatically enrolled in Medicaid through your LDSS.
- 11) You testified that your child was currently only receiving fee-for-service Medicaid coverage through your LDSS and you were advised by your

LDSS that as long as your child was in receipt of Social Security disability benefits she could not enroll in a Medicaid Managed Care plan.

- 12) You testified that you requested to end your child's Medicaid coverage with your LDSS and you were told that her coverage could not be terminated so long as she was receiving Social Security disability benefits.
- 13) You testified that you are seeking Medicaid coverage for your child through NYSOH, because you want to enroll her in a Medicaid Managed Care plan.
- 14) You testified that your child requires mental health services no longer covered under fee-for-service Medicaid and that her preferred provider does not accept fee-for-service Medicaid.
- 15) According to your account, you enrolled your child in a full cost qualified health plan, effective January 1, 2018.
- 16) You testified you are seeking eligibility for your child for Medicaid through NYSOH, because you cannot afford the full monthly premium costs of her current coverage.

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

Applicable Law and Regulations

MAGI Based Medicaid Eligibility

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

Individuals who are entitled to or enrolled in Medicare benefits under part A or B of title XVIII of the Act or are otherwise eligible for and enrolled in mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part are not eligible for MAGI based Medicaid through NYSOH (42 CFR § 435.119(b), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)). Individuals in receipt of or eligible to receive federal supplemental security income payments and/or additional state payments pursuant to title six of this article are not eligible for MAGI based Medicaid, but are eligible for standard coverage (NY Social Services Law § 366(c)(1), *see also* 42 CFR § 435.120

If an individual does not qualify for MAGI based Medicaid through NYSOH, 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)).

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 is whether NYSOH properly determined your child was eligible to enroll in a full cost qualified health plan and ineligible for Medicaid, effective January 1, 2018.

On December 13, 2017, an application for financial assistance with health insurance was submitted on behalf of your child. According to your account, that day, NYSOH received information from data sources indicating your child was actively enrolled in Medicaid through your LDSS since March 2015. As a result, your child was determined eligible to enroll in a full cost qualified health plan and ineligible for Medicaid, effective January 1, 2018. You appealed insofar as your child was not eligible for Medicaid through NYSOH.

You testified that your child is actively enrolled in Medicaid through your LDSS. You testified that she was automatically enrolled approximately two years ago when she began receiving Social Security disability benefits. You testified that your child is not eligible to enroll in a Medicaid Managed Care plan through your LDSS, so you are seeking Medicaid for her through NYSOH so she can enroll in a Medicaid Managed Care plan accepted by her preferred provider.

Pursuant to the above cited regulations, to be eligible for MAGI based Medicaid through NYSOH an individual cannot be enrolled in mandatory coverage under a State's Medicaid State plan. Furthermore, individuals in receipt of or eligible to receive federal supplemental security income payments and/or additional state payments are not eligible for MAGI based Medicaid, but are eligible for standard coverage.

Based on your testimony that your child is certified disabled and, as a result, is in receipt of Social Security disability benefits, according to the regulations, she is

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not eligible for MAGI based Medicaid, because she enrolled in mandatory coverage through your LDSS. Thus, she is not eligible for Medicaid through NYSOH.

Therefore, the December 12, 2017 eligibility determination notice stating your child was eligible for a full cost qualified health plan, and ineligible for Medicaid, was correct and is AFFIRMED.

You testified your LDSS has advised you that your child is ineligible to enroll in a Medicaid Managed Care plan and that you are unable to terminate her fee-for-service Medicaid coverage. It is noted, however, that any action, inaction, or determination taken or made by your LDSS is outside the scope of review of the NYSOH Appeals Unit. Thus, this decision does not address any issues or arguments raised pertaining to actions or determinations of your LDSS.

It is further noted, that based on the evidence establishing your child is currently enrolled in Medicaid through your LDSS, this decision does not refer your case to your LDSS.

Decision

The December 14, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: March 20, 2018

How this Decision Affects Your Eligibility

Your child remains eligible to enroll in a full cost qualified health plan

Your child is not eligible for Medicaid through NYSOH.

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.

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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
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- By fax: 1-855-900-5557

Summary

The December 14, 2017 eligibility determination is **AFFIRMED**.

Your child remains eligible to enroll in a full cost qualified health plan

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Your child is not eligible for Medicaid through NYSOH.

Legal Authority

We are sending you this notice 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)

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।

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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&etumi ama wo obi a okyerE 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.

אײדיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען איר געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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