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

Notice of Decision

Decision Date: February 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023691

[redacted]

[redacted]

On December 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 12, 2017 eligibility determination notice, July 17, 2017 eligibility determination notice, and August 30, 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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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).

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

Decision

Decision Date: February 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023691

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Was your appeal of the July 12, 2017 eligibility determination notice and July 17, 2017 eligibility determination notice timely?
>
> Did NY State of Health properly determine that you were not eligible to enroll in health insurance through NYSOH, including Medicaid, effective September 1, 2017?

Procedural History

On July 28, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid, effective September 1, 2016.

On July 11, 2017, a certified application counselor updated your household's application for financial assistance.

On July 12, 2017, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid, however, you Medicaid coverage would continue until August 31, 2017, effective July 1, 2017. This was because state and federal data sources showed that you were receiving Medicare and you are not a parent or caretaker relative of a child younger than 19 years of age.

On July 16, 2017, NYSOH redetermined your eligibility for financial assistance.

On July 17, 2017, NYSOH issued a notice of eligibility determination stating that you are no longer eligible for health insurance through NYSOH, effective September 1, 2017. This was because information from federal and state data sources showed that you were already enrolled in or eligible for a public insurance program such as Medicare.

On August 29, 2017, you updated your household's application for financial assistance.

On August 30, 2017, NYSOH issued a notice of eligibility determination stating that you do not qualify for Medicaid because, based on federal and state data sources, NYSOH determined that you were already enrolled in or eligible for a public insurance program such as Medicare.

On September 27, 2017, a certified application counselor updated your household's application for financial assistance.

On September 28, 2017, NYSOH issued a notice of eligibility determination stating that you do not qualify for Medicaid because, based on federal and state data sources, NYSOH determined that you were already enrolled in or eligible for a public insurance program such as Medicare.

On September 28, 2017, NYSOH redetermined your eligibility for financial assistance.

On September 29, 2017, NYSOH issued a notice of eligibility determination stating that you do not qualify for Medicaid because, based on federal and state data sources, NYSOH determined that you were already enrolled in or eligible for a public insurance program such as Medicare.

On October 4, 2017, you updated your household's application for financial assistance. Specifically, you changed your relationship to the [redacted] child in your household from [redacted] to [redacted].

On October 5, 2017, NYSOH issued a notice of eligibility determination stating that you do not qualify for Medicaid because, based on federal and state data sources, NYSOH determine that you were already enrolled in or eligible for a public insurance program such as Medicare.

On October 25, 2017, you updated your household's application for financial assistance. Specifically, you changed your relationship to the [redacted] child in your household from [redacted] to [redacted] That day, NYSOH issued a preliminary eligibility determination, based on that application, stating that you do not qualify for Medicaid.

Also on October 25, 2017, you spoke with NYSOH's Account Review Unit and appealed insofar as you had been found ineligible for and disenrolled from Medicaid as of August 31, 2017.

On October 26, 2017, NYSOH issued a notice of eligibility determination stating that you do not qualify for Medicaid through NYSOH because you have Medicare and are not a parent or caretaker relative of a child younger than 19 years of age.

On December 19, 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 expect to file your 2017 tax return with a tax filing status of married filing jointly. You will claim at least one dependent on that tax return. You explained that you will claim the [redacted] child listed on your application as a dependent for 2017. You went on to testify that you may claim your [redacted]-child as a dependent, however, you are not yet sure if you will do so.

2) You testified that your step-child lives with you, that you have joint-custody with her mother, and that you claim her as a dependent every other year. You will not claim your step-child as a dependent on your 2017 tax return. However, you do provide support and care to your step-child.

3) Your NYSOH account reflects that your step-child is [redacted] and that her date of birth is [redacted].

4) You initially testified that the [redacted] child listed on your application is your son and that you have had custody of him since he was [redacted] You are his primary caretaker and he does not receive any support from his biological parents. When asked further regarding your relationship to this child, you stated that he was your [redacted]. You testified that you have not adopted this child and he is considered a ward of the state.

5) You reported income of $23,444.00 for yourself consisting of $1,537.00 per month in social security disability benefits and $5,000.00 per year in self-employment income. You testified that this amount is correct. You reported that your spouse has $0.00 in income as he is out of work and collecting workers' compensation benefits. You testified that this is still correct.

6) Your application indicates that you will not be taking any deductions on your 2017 tax return. You testified that you are not sure if you will be claiming any deductions on your 2017 tax return.

7) You submitted a copy of a July 11, 2017 letter from the social security administration stating that as of December 2016 your monthly social security benefit before any deductions was $1,653.90.

8) You testified that you reside in Wyoming County.

9) You testified that you have Medicare and have had Medicare since December 2009.

10) During the hearing, you gave permission for the Hearing Officer to listen to recordings of phone calls you had with NYSOH.

11) On August 17, 2017, you placed a phone call to NYSOH. A review of the recording of that phone call reflects that you were calling to find out the status of your household's application as you received a letter advising you that your application was not completed. The NYSOH representative advised you that income documentation was needed, and extended the due date for that documentation. You placed a second call to NYSOH that same day regarding the status of a ticket that had been sent to the technical team to resolve a technical error on your account.

12) On August 29, 2017, you placed a phone call to NYSOH. A review of the recording of that phone call reflects that you were calling to find out the status of your household's coverage. You updated your household information and income information and were advised to submit income documentation.

13) On September 5, 2017, you placed a call to NYSOH. A review of the recording of that phone call reveals that you were calling for assistance signing in to your NYSOH on-line account in order to upload income documentation.

14) On September 12, 2017, you placed a call to NYSOH. A review of the recording of that phone call reveals that you were calling to find out the status of your household's application for health insurance. During that phone call, you were advised that you had been found ineligible for Medicaid as you were receiving Medicare.

15) You placed additional calls to NYSOH on September 13, 2017, September 20, 2017, September 22, 2017, and September 27, 2017.

16) On October 4, 2017, you placed a call to NYSOH. That day, you spoke with six NYSOH representatives. A review of the recording of that phone

call reflects that you were advised that you were not eligible for Medicaid through NYSOH because you had Medicare. During that phone call, you advised one of the NYSOH representatives that the [redacted] child on your application was the child of your cousin. Your application was updated to reflect that the child was your cousin rather than your ward.

17) On October 24, 2017, you placed a call to NYSOH. A review of the recording reveals that during that phone call, you requested to appeal the NYSOH determination that you were not eligible for Medicaid through NYSOH, however, no appeal was filed that day.

18) On October 25, 2017, you filed a formal appeal of the NYSOH determination that you were ineligible for Medicaid through NYSOH.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

Household Size

The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all

people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

In the case of a married couple living together, each spouse is included in the Medicaid household of the other spouse, regardless of whether they expect to file a joint tax return (42 CFR § 435.603 (f)(4)).

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)).

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 one 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)

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $20,420.00 for a three-person household (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Legal Analysis

The first issue is whether your appeal of the July 12, 2017 eligibility determination notice and July 17, 2017 eligibility determination notice was timely.

In the July 12, 2017 eligibility determination notice, NYSOH advised you that you were no longer eligible for Medicaid, but that your Medicaid would continue until August 31, 2017. This was because state and federal data sources showed that you were receiving Medicare and you were not the parent or caretaker relative of a child younger than 19 years of age. The July 17, 2017 eligibility determination notice stated that you were not eligible for Medicaid, effective September 1, 2017, because federal and state date sources showed that you were enrolled in or eligible for a public insurance program such as Medicare.

The record reflects that you first contacted NYSOH to file a formal appeal regarding your ineligibility for Medicaid through NYSOH on October 24, 2017 and did not file the formal appeal until October 25, 2017.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the July 12, 2017 or the July 17, 2017 eligibility determination notice, an appeal should have been filed by September 10, 2017 or September 25, 2017, respectively.

The record reflects that you filed your appeal on October 24, 2017, which is beyond the 60-day deadline.

As your appeal was more than 60-days after the July 12, 2017 eligibility determination notice and the July 17, 2017 eligibility determination notice, your appeal of these notices is untimely and DISMISSED.

The second issue is whether NYSOH determined that you were not eligible to receive Medicaid through NYSOH, effective September 1, 2017.

In your August 29, 2017 application, you attested that two children under the age of 19 reside with you.

The record reflects that although you assume primary responsibility for the care of the [redacted] child that resides with you, and that he is deprived of parental support by both of his parents, this child is the child of your cousin, and is therefore your first cousin once removed. Therefore, for Medicaid purposes, you are not a caretaker relative of this child.

However, the record reflects that your stepchild resides with you, that she was [redacted] the time of your August 29, 2017 application, that you assume responsibility for her care, and that she is deprived of parental support as her father is not working.

Since you meet the criteria necessary to be a caretaker relative, and since your stepchild meets the criteria necessary to be considered a dependent child, NYSOH improperly found that you were not qualified to enroll in health insurance through NYSOH, including Medicaid, effective September 1, 2017.

Therefore, the August 29, 2017 eligibility determination is RESCINDED.

You testified that you and your spouse will file your 2017 tax return as married filing jointly and will claim your [redacted] as a dependent. Although your stepchild is considered a dependent child for purposes of determining whether you are eligible for Medicaid through NYSOH, as you do not plan on claiming her as a dependent on your 2017 tax return, she is not inlcuded when determining your household size for 2017. Therefore, you are in a three-person household for 2017.

The record reflects that your household income consists of your social security benefit of $1,653.00 per month and $5,000.00 in self-employment income.

Therefore, your case is RETURNED to NYSOH to redetermine your eligibility as of August 29, 2017 based on your status as a caretaker relative, in a household of three, residing in Wyoming County, with an annual expected income of $24,836.00.

Decision

The appeal of the July 12, 2017 eligibility determination notice and the July 17, 2017 eligibility determination notice is DISMISSED as untimely.

The August 29, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility as of August 29, 2017 based on your status as a caretaker relative, in a household of three, residing in Wyoming County, with an annual expected income of $24,836.00.

Effective Date of this Decision: February 2, 2018

How this Decision Affects Your Eligibility

NYSOH improperly determined that you were ineligible for Medicaid through NYSOH because you have Medicaid as you are a caretaker relative.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance through NYSOH.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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

- By fax: 1-855-900-5557

Summary

The appeal of the July 12, 2017 eligibility determination notice and the July 17, 2017 eligibility determination notice is DISMISSED as untimely.

The August 29, 2017 eligibility determination is RESCINDED.

NYSOH improperly determined that you were ineligible for Medicaid through NYSOH because you have Medicaid as you are a caretaker relative.

Your case is RETURNED to NYSOH to redetermine your eligibility as of August 29, 2017 based on your status as a caretaker relative, in a household of three, residing in Wyoming County, with an annual expected income of $24,836.00.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance through NYSOH.

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.

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 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).