



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

Notice of Decision

Decision Date: November 15, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000018924

[REDACTED]

[REDACTED]

On October 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 4, 2017 eligibility determination notice and February 4, 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
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Decision

Decision Date: November 15, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000018924



Issues

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

Was your appeal of NY State of Health's January 4, 2017 and February 4, 2017 eligibility determination notices timely?

Did NY State of Health properly determine that your mother was eligible to enroll in the Essential Plan, effective February 1, 2017, and not eligible for Medicaid?

Procedural History

On January 3, 2017, NY State of Health (NYSOH) received your household's updated application for health insurance.

On January 4, 2017, NYSOH issued a notice of eligibility determination, stating that your mother was eligible to enroll in the Essential Plan for a limited time, with no monthly premium, effective February 1, 2017. Your mother qualified for the Essential Plan because her income was less than the allowable income limit and she was in the first five years of her qualified immigration status or she was living in the United States under color of law. This notice directed you to produce documentation of your mother's income by April 3, 2017.

On January 25, 2017, you uploaded income documentation to your NYSOH account.

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).

On January 27, 2017, you uploaded immigration documentation to your NYSOH account.

On February 2, 2017, NYSOH reviewed the income documentation you submitted and determined that this was sufficient proof of income.

On February 4, 2017, NYSOH issued a notice of eligibility determination, stating that your mother was eligible to enroll in the Essential Plan, with no monthly premium, effective March 1, 2017. Your mother qualified for the Essential Plan because her income was less than the allowable income limit and she was in the first five years of her qualified immigration status or she was living in the United States under the color of law.

On May 12, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of those eligibility determinations insofar as your mother was eligible for coverage under the Essential Plan and not eligible for Medicaid.

On October 20, 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 for fourteen days to allow you the opportunity to submit additional income documentation for your household.

On October 23, 2017, you uploaded two of your biweekly paystubs, four of your brother's weekly paystubs, and a signed and dated form from your mother attesting to no income. These documents are hereby incorporated into the record. The record is now closed.

Findings of Fact

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

- 1) You are seeking for your mother to be found eligible for Medicaid rather than the Essential Plan.
- 2) Your application states, and you confirmed, that you file your tax return as head of household and you claim your father, your mother, your brother, and your child as dependents.
- 3) You testified that your father and your brother are naturalized citizens.
- 4) You testified that your mother is currently a Resident Alien and has held that status since [REDACTED] 2009. You further testified that your mother has applied to become a United States citizen and recently went to have her [REDACTED] taken.

- 5) You testified that your mother and father are married. They do not file a tax return. They do not have any income.
- 6) You testified that your brother is [REDACTED], he has a part-time job, is not a student, and does not file a tax return.
- 7) Your NYSOH account reflects that you are [REDACTED].
- 8) You provided documentation in the form of your mother's Resident Alien card. This card indicates that your mother has been a resident since March 4, 2009. The card lists an expiration date of January 27, 2025.
- 9) The application that was submitted on January 3, 2017, which requested financial assistance, listed your annual income as \$20,800.00, your father's annual income as \$0.00, your mother's annual income as \$0.00, your brother's annual income as \$3,000.00, and your child's income as \$0.00.
- 10) On January 25, 2017, you uploaded a form signed by your mother dated January 3, 2017 attesting to no income.
- 11) On February 2, 2017, NYSOH reviewed the income documentation you submitted on January 25, 2017 and determined that this was sufficient proof of your household's income.
- 12) You testified that your household's income has since changed as you changed jobs and your brother's income has changed.
- 13) During the hearing, you gave permission for the Hearing Officer to listen to recordings of phone calls you had with NYSOH.
- 14) The record reflects that on February 21, 2017 you placed a call to NYSOH and spoke to the NYSOH Account Review Unit requesting that your mother be found eligible for Medicaid rather than the Essential Plan. No incident or complaint was created as a result of this contact.
- 15) The record reflects that on March 24, 2017 you placed a call to NYSOH and spoke to the NYSOH Account Review Unit requesting that your mother be found eligible for Medicaid rather than the Essential Plan. No incident or complaint was created as a result of this contact.
- 16) On March 29, 2017, you again spoke to the NYSOH Account Review Unit. As a result of this contact, three incidents were created [REDACTED]. The notes within these incidents reflect that you were requesting that your mother be found eligible for Medicaid rather than the Essential Plan. Notes dated March 29, 2017 in incident

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term “modified adjusted gross income” means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

With regard to eligibility for financial assistance through the Marketplace, a tax filer’s household income includes the MAGI of all the individuals in the taxpayer’s household who are required to file a federal tax return for the taxable year (26 CFR § 1.36B-1(e)(1); 42 CFR § 435.603(d)(1)). The MAGI-based income of a child or tax dependent who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

A person is not required to file a tax return if their gross income is less than the sum of the exemption amount plus the basic standard deduction allowable for that person (26 USC § 6012(1)(A)). For the 2017 year, a dependent who had yearly gross earned income greater than \$6,300.00 or gross unearned income greater than \$1,050.00 would be required to file a tax return (see IRS Revenue Procedure 2014-61).

Household Size

In the case where a parent is claimed by their child as a dependent and does not expect to file a tax return themselves, if living with the individual, the individual’s household includes the individual’s spouse and the individual’s children under the age of 19 (or in the case of full-time students, age 21) (42 CFR §603(f)(3)).

With regard to the Essential Plan, the household size is determined using the above methodology for individuals who do not file a tax return. (New York’s Basic Health Plan Blueprint, pg. 19-20, as approved January 2017; see <https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf>).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (see 42 CFR § 600.305, 42 CFR

§ 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is \$20,160.00 for a three-person household (81 Fed. Reg. 4036.).

A person who has a household income that is at or below 150% of the FPL has a \$0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2017; see <https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf>).

Medicaid

A person who meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard is eligible for Medicaid benefits (45 CFR § 155.305(c)). One of the non-financial criteria for Medicaid eligibility is the immigration status of the person applying for health insurance. A person is eligible for Medicaid when his or her immigration status is satisfactory and he or she meets all other requirements for Medicaid (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

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).

Qualified Immigrants

In NY State, qualified immigrants who were formerly eligible for Medicaid through the state, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of January 1, 2016 (New York's Basic Health Plan Blueprint, p. 19, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>). This category of qualified immigrants includes individuals lawfully admitted for permanent residence in the United States who are still in their first five years of permanent residency. (18 NYCRR § 349.3, 8 USC § 1613).

Legal Analysis

The first issue is whether your appeal of NYSOH's January 4, 2017 and February 4, 2017 eligibility determination notices was timely.

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).

On January 4, 2017, NYSOH issued a notice of eligibility determination stating that your mother was eligible for the Essential Plan for a limited time, effective February 1, 2017. Thereafter, on February 4, 2017, NYSOH issued a notice of eligibility determination stating that your mother was eligible for the Essential Plan, effective March 1, 2017.

The record reflects that you first contacted NYSOH to file a formal appeal regarding the January 4, 2017 and February 4, 2017 eligibility determination notices on May 12, 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 issue of your mother's eligibility for the Essential Plan rather than Medicaid as of February 1, 2017 and as of March 1, 2017, an appeal should have been filed by March 5, 2017 and April 5, 2017, respectively.

Although your appeal was untimely on its face, you contacted the NYSOH Account Review Unit on February 21, 2017 regarding your request that your mother be found eligible for Medicaid rather than the Essential Plan as of February 1, 2017. This contact was within the 60-day time frame to appeal. NYSOH did not create an incident regarding this request.

You contacted the NYSOH Account Review Unit on March 24, 2017 to follow-up on this request. Again, NYSOH did not create an incident regarding this request.

Thereafter, on March 29, 2017, you contacted the NYSOH Account Review Unit to follow-up on your request. At this time, three incidents were created with regard to your request. This contact was within 60-days of your initial request on February 21, 2017. These incidents reflect that your case was escalated to another department. There is no indication regarding the resolution of this escalation.

On April 21, 2017, you contacted the NYSOH Account Review Unit to follow-up on your request. Another incident was created as a result of this contact, and your account was again escalated to another department. There is no indication regarding the resolution of this escalation.

On May 21, 2017, you again contacted the NYSOH Account Review Unit regarding your request that your mother be found eligible for Medicaid rather than the Essential Plan. An incident was created with regard to that request. The notes within this incident indicate that you were advised that NYSOH had declined to grant your request. It was at this time that you filed an appeal of the January 4, 2017 and February 4, 2017 eligibility determination notices.

As you contacted NYSOH on February 21, 2017 requesting that your mother be found eligible for Medicaid rather than the Essential plan, which was within 60-days of the January 4, 2017 and February 4, 2017 eligibility determination notices, you continued to follow-up with NYSOH regarding your request, and you filed your appeal the same day you were advised that NYSOH was declining to grant your request, your appeal was timely and will be addressed.

The second issue under review is whether NYSOH properly determined that your mother was eligible to enroll in the Essential Plan, effective February 1, 2017, and not eligible for Medicaid.

The record reflects that your mother does not file taxes and that she resides with her spouse, and one child under the age of 19. Therefore, your mother is in a three-person household consisting of herself, her spouse, and your brother.

The applications that were submitted on January 3, 2017 and February 3, 2017 listed income for your mother of \$0.00, income for your father of \$0.00, and income for your brother of \$3,000.00.

Therefore, your mother's annual household income in the applications submitted on January 3, 2017 and February 3, 2017 was \$0.00 and the eligibility determination relied upon that information.

The Essential Plan is provided through NYSOH to individuals who are lawfully present non-citizens who are ineligible for Medicaid or Child Health Plus as a result of their immigration status, and have a household income that is between 0% and 200% of the FPL. Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size.

On the date of your application, the 2016 FPL was \$20,160.00 for a three-person household and the 2017 FPL was \$20,420.00. Since an annual income of \$0.00 is 0% of the 2016 FPL and 0% of the 2017 FPL, your mother meets the financial eligibility criteria for both the Essential Plan and Medicaid.

As of January 1, 2016, legal permanent residents who were receiving Medicaid through NY State, but were not eligible for Medicaid under federal law due to being in the first five years of their permanent residency, must now receive coverage through the Essential Plan. The record indicates that NYSOH determined that you were in the first five years of your qualified immigration status and thus not eligible for Medicaid

However, you testified and provided documentation that your mother is a permanent Resident Alien, and has been a permanent resident since [REDACTED],

2009. Since your mother is not within the first five years of her qualified immigration status she should not have been denied Medicaid on that basis.

Therefore, since the January 4, 2017 and February 4, 2017 eligibility determination notices improperly stated that your mother was within the first five years of her qualified immigration status and thus not eligible for Medicaid they are RESCINDED.

Decision

The January 4, 2017 eligibility determination notice is RESCINDED.

The February 4, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your mother's Medicaid coverage as of February 1, 2017.

Effective Date of this Decision: November 15, 2017

How this Decision Affects Your Eligibility

Your mother was improperly found eligible for the Essential Plan on the basis of her immigration status.

Your case is being sent back to NYSOH to reinstate your mother's Medicaid coverage as of February 1, 2017.

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

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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 January 4, 2017 eligibility determination notice is RESCINDED.

The February 4, 2017 eligibility determination notice is RESCINDED.

Your mother was improperly found eligible for the Essential Plan on the basis of her immigration status.

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Your case is RETURNED to NYSOH to reinstate your mother's Medicaid coverage as of February 1, 2017.

Your case is being sent back to NYSOH to reinstate your mother's Medicaid coverage as of February 1, 2017.

Legal Authority

We are issuing this determination 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&btumi ama wo obi a okyerε 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.

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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