STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: February 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025462

[redacted]

[redacted]

On February 20, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 15, 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
  PO 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(b).

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: February 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025462

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Issues

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

> Did NY State of Health (NYSOH) properly determine that your spouse was eligible for Medicaid, effective November 1, 2017?
>
> Did NYSOH properly determine that your spouse was not eligible for the Essential Plan?

Procedural History

On November 13, 2017, NYSOH received an updated application for financial assistance with health insurance.

Also on November 13, 2017, NYSOH received a copy of your spouse's valid U.S. Passport.

On November 14, 2017, NYSOH issued an eligibility determination notice stating that your spouse was conditionally eligible for Medicaid, effective November 1, 2017. You were requested to provide proof of her citizenship status to NYSOH by February 11, 2018 to confirm her eligibility.

Also on November 14, 2017, NYSOH redetermined your household's eligibility for financial assistance with health insurance.

On November 15, 2017, NYSOH issued an eligibility determination notice stating that your spouse remained eligible for Medicaid, effective November 1, 2017.

Also on November 15, 2017, NYSOH issued an enrollment notice confirming your selection of a Medicaid Managed Care (MMC) plan for your spouse's coverage as of November 14, 2017, with such coverage beginning effective December 1, 2017.

On December 6, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as your spouse was not found eligible for the Essential Plan; specifically, the Essential Plan 4.

On February 20, 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 support the following findings of fact:

1) You testified that you were only seeking an appeal with respect to your spouse's eligibility.

2) You testified, and your NYSOH account reflects, that your spouse had been enrolled in the Essential Plan 4 until September 30, 2017.

3) You testified that you were seeking for her to be reenrolled in the Essential Plan 4 because it provided her greater flexibility to see physicians without seeking pre-approval or advance scheduling that is required under her MMC plan.

4) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. Your NYSOH account reflects that you will claim no dependents on that tax return; however, you testified that you anticipated claiming your mother as a dependent.

5) The application that was submitted on November 13, 2017, and the subsequent redetermination by NYSOH on November 14, 2017, listed annual household income of $0.00, as you and your spouse are currently unemployed and relying upon your savings to sustain your household. You testified that this amount was correct.

6) You live in [redacted], New York.

7) On November 13, 2017, you provided to NYSOH a copy of your spouse's U.S. passport issued to her on [redacted], 2016, and valid until [redacted] 2026.

8) You testified that your spouse became a naturalized U.S. citizen on or about [redacted] 2016.

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)).

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 $16,240.00 for a two-person household (82 Federal Register 8831).

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 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your spouse was eligible for Medicaid, effective November 1, 2017.

On November 13, 2017, NYOSH received your application for financial assistance with health insurance, this application listed an annual household income of $0.00. This application also reflected that your spouse was no longer an immigrant non-citizen, but rather a U.S. citizen.

In response to this application, your spouse was found conditionally eligible for Medicaid, effective November 1, 2017, pending the NYSOH receipt of proof of your spouse's citizenship status.

That same day, on November 13, 2017, you provided to NYSOH a copy of your spouse's U.S. passport issued to her on [redacted], 2016, and valid until [redacted], 2026.

Based on this additional information, NYSOH redetermined your household's eligibility on November 14, 2017, which again listed an annual household income of $0.00 and reflecting that your spouse was a U.S. citizen. The eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2017 income taxes as married filing jointly. Both your November 13, 2017 application and November 14, 2017 redetermination by NYSOH reflected that and will not claim any dependents on that tax return.

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 relevant FPL was $16,240.00 for a two-person household. Since $0.00 is 0.00% of the 2017 FPL, NYSOH properly found your spouse to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

The second issue under review is whether NYSOH properly determined that your spouse was not eligible for the Essential Plan; specifically, the Essential Plan 4.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,240.00 for a one-person household. Since an annual household income of $0.00 is 0.00% of the 2017 FPL, NYSOH properly found you to be eligible for the Essential Plan.

Furthermore, the Essential Plan 4 is only available to qualified immigrant non-citizens who have an annual income less than 138% of the applicable FPL. Since your NYSOH account reflects, and the documentation you provided confirms, that your spouse is a U.S. Citizen, she is not eligible for the Essential Plan 4.

Since the November 15, 2017 eligibility determination properly stated that, based on the information you provided, your spouse was eligible for Medicaid, and not eligible for the Essential Plan, it is correct and is AFFIRMED.

Decision

The November 15, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 27, 2018

How this Decision Affects Your Eligibility

Your spouse was eligible for Medicaid, effective November 1, 2017.

Your spouse was not eligible for the Essential Plan.

PLEASE NOTE: If you wish to change your application to include a dependent, you must contact NYSOH to update your application.

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
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The November 15, 2017 eligibility determination notice is AFFIRMED.

Your spouse was eligible for Medicaid, effective November 1, 2017.

Your spouse was not eligible for the Essential Plan.

PLEASE NOTE: If you wish to change your application to include a dependent, you must contact NYSOH to update your application.

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।

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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 नि:शुल्क 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.

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