



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

## Notice of Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000028604

[REDACTED]

[REDACTED]

On April 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 8, 2018 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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## Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000028604



## Issue

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

Did NY State of Health (NYSOH) properly determine that you were eligible for Emergency Medicaid effective February 1, 2018?

## Procedural History

On February 7, 2018, NYSOH received your application for financial assistance with health insurance. That day, a preliminary eligibility determination was prepared finding you eligible to receive Emergency Medicaid, effective February 1, 2018.

Also on February 7, 2018, you spoke to the NYSOH's Accounts Review Unit and appealed the eligibility determination insofar as you were eligible for Medicaid coverage for the treatment of emergency medical conditions only and not eligible for full Medicaid.

On February 8, 2018, NYSOH issued an eligibility determination notice stating that you remained eligible for Medicaid coverage for the treatment of emergency medical conditions only, effective February 1, 2018, and not eligible to enroll in a health plan. This notice stated that this was because you are not a citizen, qualified alien, or permanently residing in the United States under color of law (PRUCOL).

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On April 13, 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 testified that you are requesting full Medicaid through this appeal because you are seeking medical treatment that requires more than Emergency Medicaid.
- 2) You testified that you do not have a valid visa or other immigration status.
- 3) You testified you do not have a current application before any federal immigration agency for an immigration status or for other relief.
- 4) You testified that you are not working and have an annual expected income of \$0.00.
- 5) Your application states that you file taxes with a status of single and that you have no dependents.
- 6) According to your NYSOH account, you reside in Suffolk County, NY.

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 2018 FPL, which is \$12,140.00 for a one-person household (83 Federal Register 2642).

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).

### Emergency Medicaid

In some cases, Medicaid will pay for emergency medical treatment for a person who does not have evidence of citizenship or immigration status, even if the person cannot get full Medicaid coverage (NY Soc. Serv. Law § 122(1)(e); 18 NYCRR § 360-3.2(j)(3)(ii)(a)).

The term “emergency medical condition” means:

A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (a) Placing the patient’s health in serious jeopardy;
- (b) Serious impairment of bodily functions; or
- (c) Serious dysfunction of any bodily organ or part

(18 NYCRR § 360-3.2 (iii)(a)-(c)).

To get treatment for an emergency medical condition, an undocumented alien who is not a temporary non-immigrant must meet all of the other Medicaid eligibility requirements, including proof of identity, income, and State residence (GIS 13 MA/09: Changes to Medicaid Coverage for the Treatment of an Emergency Medical Condition, (2/25/2013)).

### Citizenship and Immigration Status

To enroll through NYSOH, an applicant must be a citizen or national of the United States, or a non-citizen lawfully present in the United States and reasonably expecting to become a citizen or remain a lawfully present noncitizen for the entire period for which enrollment is being sought (45 CFR § 155.305(a)(1), 42 CFR § 600.305, 42 CFR §435.406).

NYSOH must verify or obtain information in order to determine that an applicant is eligible for enrollment in a qualified health plan, the Essential Plan, and Federal Medicaid, including the certification of citizenship, status as a national, or lawful presence (45 CFR § 155.315(a),(c), 42 CFR § 600.305, 42 CFR §435.406).

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Under federal law, certain individuals who enter the United States on or after August 22, 1996, are not eligible for any Federal means-tested public benefit, including federal Medicaid (8 U.S. Code § 1613(a)).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that you were eligible for Emergency Medicaid only, effective February 1, 2018.

NYSOH received your application for financial assistance with health insurance on February 7, 2017. On February 8, 2018, NYSOH issued an eligibility determination notice finding you were eligible for Medicaid coverage for the treatment of emergency medical conditions only, effective February 1, 2018.

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.

You are in a one-person household for purposes of this analysis. This is because you expect to file your 2018 income tax return as single and will not claim any dependents on that tax return.

On the date of your application, the relevant FPL was \$12,140.00 for a one-person household. Since \$0.00 is 0% of the 2018 FPL, you would meet the financial requirements for Medicaid. However, to be eligible for full Medicaid, an individual also needs to meet the non-financial requirements, including having a valid immigration status. In some cases, Medicaid will pay for emergency medical treatment for a person who does not have evidence of citizenship or immigration status, even if the person cannot get full Medicaid coverage.

The February 8, 2018 notice states that you were only eligible for emergency Medicaid for medical care and services because you were not a citizen, qualified alien, or PRUCOL.

You testified that you do not have a valid visa or other immigration status. You further testified that you do not have a current application before any federal immigration agency for an immigration status or for other relief.

To be eligible for full Medicaid coverage through NYSOH, you must provide proof of your citizenship or immigration status. Since you credibly testified that you do not have proof your immigration status and you are not a PRUCOL individual, you are not eligible for full Medicaid coverage through NYSOH.

However, since the evidence establishes you are residing in the state of New York with an expected annual household income below the threshold to qualify for Medicaid, you meet the criteria to receive emergency Medicaid coverage.

Therefore, NYSOH's February 8, 2018 eligibility determination notice finding you eligible for the Medicaid for the treatment of emergency medical conditions only is correct and must be AFFIRMED.

## **Decision**

The February 8, 2018 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** April 19, 2018

## **How this Decision Affects Your Eligibility**

You were properly determined to be eligible for Emergency Medicaid only, effective February 1, 2018.

## **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 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

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).

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 February 8, 2018 eligibility determination notice is **AFFIRMED**.

You were properly determined to be eligible for Emergency Medicaid only, effective February 1, 2018.

### **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**

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).

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 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 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&tumi 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.

## **אידיש (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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