



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

Notice of Decision

Decision Date: December 1, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000008834

[REDACTED]

Dear [REDACTED],

On November 3, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's February 3, 2016 eligibility determination and disenrollment notices.

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 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
DEPARTMENT OF HEALTH
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Decision

Decision Date: December 1, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000008834

[REDACTED]

Issue

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

Did NY State of Health (NYSOH) properly determined that you were no longer eligible for Medicaid, but eligible for the Essential Plan instead, effective March 1, 2016?

Procedural History

On November 14, 2015, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid, effective November 1, 2015. The notice further stated that you needed to provide proof of your Social Security number by February 11, 2016.

Also on November 14, 2015, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a Medicaid Managed Care (MMC) plan, effective December 1, 2015.

On January 8, 2016, a copy of your Social Security card was uploaded to your NYSOH account.

On February 2, 2016, NYSOH reviewed your account.

On February 3, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with no monthly premium, effective March 1, 2016. The notice also stated that your Medicaid eligibility would end on February 29, 2016.

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Also on February 3, 2016, NYSOH issued a disenrollment notice stating that your enrollment in your MMC plan would end effective February 29, 2016.

On February 25, 2016, NYSOH issued a notice of enrollment confirmation confirming your enrollment in an Essential Plan 4, effective March 1, 2016.

On March 2, 2016, you updated your NYSOH account.

On March 3, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in a qualified health plan (QHP) at full cost, effective April 1, 2016.

Also on March 3, 2016, NYSOH issued a disenrollment notice stating that your coverage in your Essential Plan 4 would end effective March 31, 2016.

On April 1, 2016, a document was uploaded to your NYSOH account.

On April 4, 2016, you updated your NYSOH account multiple times.

On April 5, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective May 1, 2016.

Also on April 5, 2016, you updated your NYSOH account several times.

On April 6, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to \$251.00 per month in advance payments of the premium tax credit (APTC), and eligible to receive cost-sharing reductions, effective May 1, 2016.

On April 11, 2016, you spoke with NYSOH's Account Review Unit and requested an appeal, insofar as your eligibility for Medicaid and enrollment in your MMC plan had ended as of February 29, 2016.

On November 3, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You were joined on the phone by [REDACTED], an employee of the U.S. Committee for Refugees and Immigrants, who was sworn in and provided testimony. 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) On November 13, 2015, you completed an application for financial assistance through NYSOH.
- 2) Also on November 13, 2015, Albany County Department of Social Services faxed documentation to NYSOH on your behalf, consisting of:
 - a. A one-page DOH identity verification form;
 - b. A one page I-94 from U.S. Customs and Border Protection entitled "Most Recent I-94" stating that your most recent date of entry into the United States was October 20, 2015, and that your class of admission was "RE".
 - c. A one-page document signed by the Director for the Office of Refugee Admissions with your photo and an issue date of October 13, 2015 stating that your application to apply for admission to the United States was approved pursuant to section 2017(c)(1) (document [REDACTED]).
- 3) You testified that you arrived in the United States as a refugee from Iraq in October 2015.
- 4) You testified that, when you first arrived, you had no income and were found eligible for Medicaid.
- 5) You testified that, at some point, your MMC coverage was not working, so you contacted NYSOH to update your account.
- 6) You testified that, when you updated your account, you were found eligible for the Essential Plan.
- 7) The record reflects that NYSOH issued an eligibility determination stating that you were eligible for the Essential Plan as of March 1, 2016 because: "Your household income is less than the allowable income limit of \$16,243.00 for Essential Plan. The household income listed in your application is \$0.00" and "You are in the first five years of your qualified immigration status OR are living in the United States under the color of law (PRUCOL)."
- 8) You testified that your understanding was that you would remain eligible for Medicaid for at least eight months, regardless of whether there was any change in your income, based on your status as a refugee.

- 9) The record reflects that you updated your NYSOH application to a non-financial application on March 2, 2016. You testified that you did not know that you had done this, and that your only intent in updating your application was to try to be found eligible for Medicaid again.
- 10) Your NYSOH account contains a note from a NYSOH representative made on July 5, 2016 which states, "Consumer should've had Medicaid due to immigration status." Further, the enrollment history in your NYSOH account indicates that you were enrolled into Fee-For-Service Medicaid for the months of April and May of 2016.
- 11) You testified that, at some point, you were informed that you had Medicaid coverage for the month of April 2016, but that you have an outstanding bill for that month that you have been unable to get covered.

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

Applicable Law and Regulations

Medicaid Eligibility

Medicaid through NYSOH can be provided 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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

Most individuals determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a twelve month period. This 12-month period is referred to as "continuous coverage" and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

Transition to Essential Plan:

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>).

Certain qualified aliens who entered the U.S. on or after August 22, 1996, receive Medicaid coverage with State and local funds until they have resided in the U.S. as a qualified alien for five years (five year ban).

However, certain qualified aliens who entered the U.S. on or after August 22, 1996 and are in certain categories are exempt from the federal five-year-ban on Medicaid.

The following qualified aliens who entered the United States on or after August 22, 1996, may receive all care and services available under the Medicaid program, provided they are determined to be otherwise eligible:

(A) An alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act [8 USC 1157];

(B) An alien who is granted asylum under section 208 of such Act [8 USC 1158];

(C) An alien whose deportation is being withheld under section 243(h) of such Act [8 USC 1253] (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of such Act [8 USC 1231(b)(3)] (as amended by section 305(a) of division C of Public Law 104-208);

(D) An alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980;

(E) An alien admitted to the United States as an Amerasian immigrant as described in section 1612(a)(2)(A)(i)(V) (1) of this title.

(see 8 USC § 1613; NY Social Services Law § 122(1); 18 NYCRR § 349.3).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible for Medicaid, and were eligible instead for the Essential Plan, effective March 1, 2016.

On November 14, 2015, NYSOH issued an eligibility determination notice stating that, based on your household income of \$0.00, you were conditionally eligible for Medicaid effective November 1, 2015. That same day, NYSOH issued a notice confirming that you were enrolled in a MMC plan, with a plan enrollment start date of December 1, 2015.

On February 3, 2016, NYSOH issued an eligibility redetermination notice that you were eligible to enroll in the Essential Plan, effective as of March 1, 2016. The notice states, in relevant part, that you qualify to enroll in the Essential Plan because the household income listed in your application is \$0.00, and “[y]ou are in the first five years of your qualified immigration status OR are living in the United State under the color of law (PRUCOL).” Furthermore, NYSOH issued a disenrollment notice stating that your coverage in your MMC plan would end effective February 29, 2016.

Generally, once adults are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage. This 12-month period is based on the start date of the original Medicaid eligibility determination.

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. Certain qualified aliens who entered the U.S. on or after August 22, 1996, could only receive Medicaid coverage with State and local funds until they have resided in the U.S. as a qualified alien for five years.

However, federal and state law provides that certain qualified aliens who entered the United States on or after August 22, 1996, may receive all care and services available under the Medicaid program and are exempt from the federal five-year ban. This includes qualified aliens who have been granted refugee status.

You testified that you came to the United States from Iraq in October of 2015 as a refugee. On the day of your application, November 13, 2015, Albany County DSS faxed to NYSOH a copy of your I-94, showing your status as a refugee, and a document from the Director for the Office of Refugee Admissions with your photo and an issue date of October 13, 2015 stating that your application to apply for admission to the United States was approved pursuant to section 2017(c)(1), which, as stated above, is a section of the United States Code that pertains to the admission of refugees to the United States (see Document

██████████ Therefore, NYSOH had sufficient documentation on the day of

your initial application to conclude that you are in the United States with refugee status.

There is nothing in the record to indicate that your eligibility for Medicaid otherwise changed after you were approved for Medicaid coverage in November 2015. Therefore, NYSOH's determination stating that you were no longer eligible for Medicaid and were instead eligible for the Essential Plan was not correct and is RESCINDED.

Additionally, since you remained eligible for Medicaid, you also remained eligible for your MMC plan. Therefore, the February 3, 2016 disenrollment notice, stating that your enrollment in your MMC plan ended as of February 29, 2016, is RESCINDED.

Decision

The February 3, 2016 eligibility determination notice stating that you are eligible for the Essential Plan, effective March 1, 2016, is RESCINDED.

The February 3, 2016 disenrollment notice stating that your MMC coverage ended as of February 29, 2016 is RESCINDED.

The November 14, 2015 eligibility determination notice stating that you were eligible for Medicaid November 1, 2015 is REINSTATED.

The November 14, 2015 enrollment confirmation notice stating that your enrollment in your MMC plan began on December 1, 2015 is REINSTATED.

The March 3, 2016 eligibility determination stating that you were eligible to enroll in a QHP at full cost effective April 1, 2016 is RESCINDED.

Your case is RETURNED to NYSOH to facilitate your re-enrollment into Medicaid and your MMC plan, effective November 1, 2015, for a period of twelve months.

Effective Date of this Decision: December 1, 2016

How this Decision Affects Your Eligibility

You are eligible for Medicaid coverage from November 1, 2015 through October 31, 2016.

You are enrolled in your MMC plan from December 1, 2015 through October 31, 2016.

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).

Your case has been returned to NYSOH to properly effectuate your enrollment into your Medicaid and MMC coverage.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 3, 2016 eligibility determination notice stating that you are eligible for the Essential Plan, effective March 1, 2016, is **RESCINDED**.

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The February 3, 2016 disenrollment notice stating that your MMC coverage ended as of February 29, 2016 is RESCINDED.

The November 14, 2015 eligibility determination notice stating that you were eligible for Medicaid November 1, 2015 is REINSTATED.

The November 14, 2015 enrollment confirmation notice stating that your enrollment in your MMC plan began on December 1, 2015 is REINSTATED.

The March 3, 2016 eligibility determination stating that you were eligible to enroll in a QHP at full cost effective April 1, 2016 is RESCINDED.

Your case is RETURNED to NYSOH to facilitate your re-enrollment into Medicaid and your MMC plan, effective November 1, 2015, for a period of twelve months.

You are eligible for Medicaid coverage from November 1, 2015 through October 31, 2016.

You are enrolled in your MMC plan from December 1, 2015 through October 31, 2016.

Your case has been returned to NYSOH to properly effectuate your enrollment into your Medicaid and MMC coverage.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

