



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

Notice of Decision

Decision Date: March 23, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025518

[REDACTED]

Dear [REDACTED],

On February 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 18, 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.

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
PO Box 11729
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Decision

Decision Date: March 23, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025518

[REDACTED]

Issue

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

Did NY State of Health (NYSOH) properly disenroll you from your Essential Plan coverage, effective November 1, 2017?

Procedural History

On May 17, 2017, NYSOH issued an eligibility determination notice, stating you were eligible to enroll in the Essential Plan with no monthly premium, for a limited time, effective July 1, 2017. You were directed to provide proof of date you obtained your current immigration status by August 14, 2017 to finalize your eligibility, and you were enrolled in a plan.

On August 21, 2017, NYSOH issued an eligibility determination notice, stating that you were no longer eligible for financial assistance through NYSOH because you had not provided documentation regarding the date you obtained your current immigration status. You were eligible to enroll in a full cost plan. That same day, NYSOH issued an enrollment notice, stating that your Essential Plan coverage would end on September 30, 2017.

On September 5, 2017 you updated your application.

On September 6, 2017, NYSOH issued an eligibility determination notice, stating you were eligible to enroll in the Essential Plan with no monthly premium, for a limited time, effective October 1, 2017. You were directed to provide proof of the

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date you obtained your current immigration status by December 4, 2017 to finalize your eligibility, and you were again enrolled in the Essential Plan.

On November 16, 2017, you submitted additional immigration documents.

On November 18, 2017, NYSOH issued an eligibility determination notice, stating that you were eligible for Medicaid, effective November 1, 2017, and no longer eligible for the Essential Plan. You were directed to select a Medicaid Managed Care (MMC) plan, and subsequently you were disenrolled from the Essential Plan effective November 30, 2017.

On November 23, 2017, NYSOH issued a notice confirming your enrollment in an MMC plan, effective January 1, 2018.

On December 7, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your MMC enrollment, because your health care provider did not accept fee-for-service Medicaid.

On February 12, 2018, you and had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed and closed at the end of the hearing.

Findings of Fact

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

- 1) On July 3, 2016, you provided a copy of your permanent resident card, which indicated that your immigration category was CR6, you had been a resident since January 31, 2012, and your card expired January 31, 2014.
- 2) On November 16, 2017, you provided a copy of your [REDACTED], including an I-551 visa for your residence in the US. The visa, evidencing permanent residency for one year, was issued on May 16, 2017 and is valid until May 15, 2018. Your alien number was listed as [REDACTED], with an immigration category of [REDACTED].
- 3) You testified that you were satisfied with your eligibility for Medicaid, and that you were not concerned with the start date of your enrollment in your MMC plan. However, you were dissatisfied with the end date of your enrollment in your Essential Plan.
- 4) You were directed in the May 17, 2017 and September 6, 2017 notices of eligibility determination to provide documentation regarding your immigration status. You did not provide additional documentation to NYSOH until November 16, 2017. That documentation indicated that, at

least from May 16, 2017 to May 15, 2018, your immigration status was [REDACTED].

- 5) You were found ineligible for the Essential Plan in the notices issued on November 18, 2017.

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

Applicable Law and Regulations

Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf>).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any updates in eligibility to the Essential Plan effective the first day of the following month for changes received by NYSOH from the first to the fifteenth of any month (45 CFR § 155.420(b)(1)(i); see also 42 CFR § 600.320(c)). For updates received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR § 155.420(b)(1)(ii); see also 42 CFR § 600.320(c)).

Immigration Status

According to the US Citizenship and Immigration Services website, a "CR6" immigration category is a conditional status granted to a spouse of a US citizen <https://www.uscis.gov/sites/default/files/ocomm/ilink/0-0-0-32054.html>, retrieved March 20, 2018). "TR6" refers to a spouse of a US citizen, whose conditional status has been denied or reopened.

Legal Analysis

The issue under review is whether NYSOH properly disenrolled you from your Essential Plan coverage, effective November 1, 2017.

Your account confirms that because of your new eligibility for Medicaid, you were determined ineligible for the Essential Plan in the notice of eligibility

determination issued on November 18, 2017, and disenrolled from your Essential Plan coverage.

However, at the time of the November 18, 2017 eligibility redetermination, you were already enrolled in an Essential Plan. In accordance with the above regulations, for updates in eligibility for the Essential Plan received after the fifteenth day of the month, NYSOH must implement any resulting changes on the first day of the second following month. Since the eligibility redetermination in this case occurred after the fifteenth day of the month, your Essential Plan coverage should not have been terminated prior to January 1, 2018.

Therefore, the November 18, 2017 notices are MODIFIED to reflect that your eligibility for and your enrollment in Essential Plan coverage ended December 31, 2017.

Decision

The November 18, 2017 notices are MODIFIED to reflect that your eligibility for and your enrollment in Essential Plan coverage ended December 31, 2017.

Your case is RETURNED to NYSOH to correct the end date of your Essential Plan coverage.

Effective Date of this Decision: March 23, 2018

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to change the end date of your Essential Plan coverage to December 31, 2017.

Please be aware that you should update your immigration status before it expires.

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

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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 appeal 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):

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- By calling the Customer Service Center at 1-855-355-5777
- By mail at:
NY State of Health Appeals
P.O. Box 11729

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The November 18, 2017 notices are MODIFIED to reflect that your eligibility for and your enrollment in Essential Plan coverage ended December 31, 2017.

Your case is RETURNED to NYSOH to correct the end date of your Essential Plan coverage.

Your case is being sent back to NYSOH to change the end date of your Essential Plan coverage to December 31, 2017.

Please be aware that you should update your immigration status before it expires.

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 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 אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.