



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

## Notice of Decision

Decision Date: March 23, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000012423

[REDACTED]

Dear [REDACTED]

On January 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 21, 2016 eligibility determination notice and enrollment confirmation 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 NY State of Health 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.

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## Decision

Decision Date: March 23, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000012423

[REDACTED]

## Issue

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

Did NY State of Health (NYSOH) properly determine you were not eligible to enroll in a Medicaid Managed Care plan?

## Procedural History

On September 21, 2016, NYSOH issued an eligibility determination notice stating you were conditionally eligible for Medicaid, effective September 1, 2016. The notice directed you to provide proof of termination of your coverage through **Tricare** by November 4, 2016 or you might lose your insurance or receive less help paying for coverage.

Also on September 21, 2016, NYSOH issued a notice of enrollment confirmation stating the type of Medicaid coverage you were eligible for did not require/ allow you to enroll in a health plan.

On October 6, 2016, you contacted NYSOH's Account Review Unit and requested an appeal insofar as you were not eligible to enroll in a Medicaid Managed Care plan.

On December 26, 2016, NYSOH issued an eligibility determination notice stating you were newly eligible to purchase a full-cost qualified health plan through NYSOH, effective February 1, 2017. The notice further indicated you were ineligible for Medicaid because data sources indicated you were already insured through a public insurance program such as **Tricare**.

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On January 26, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open until February 16, 2017 for you to submit proof you were not enrolled in health coverage through **Tricare** in September 2016. NYSOH received no such documentation by February 16, 2017 and the record closed thereafter.

## Findings of Fact

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

- 1) You were determined fully eligible for Medicaid as of September 1, 2015 and enrolled in a Medicaid Managed Care plan, effective October 1, 2015.
- 2) You were disenrolled from your Medicaid Managed Care plan as of August 31, 2016, because you failed to timely renew your coverage for the 2016 coverage year.
- 3) On September 20, 2016, NYSOH received information from state and federal data sources indicating you were enrolled in health coverage through **Tricare as** of September 1, 2016. The same day NYSOH systematically redetermined your eligibility.
- 4) NYSOH determined you conditionally eligible for fee-for-service Medicaid, as of September 1, 2016, and directed you to submit proof by November 4, 2016 that your health coverage through **Tricare** had been terminated.
- 5) You were not eligible to enroll in a Medicaid Managed Care plan during this conditional eligibility period.
- 6) NYSOH did not receive proof by the November 4, 2016 deadline that your **Tricare** coverage had been terminated.
- 7) Your eligibility was systematically redetermined on December 26, 2016 wherein you were found ineligible for financial assistance through NYSOH because you failed to submit proof your health coverage through Tricare had been terminated.
- 8) You testified you have never had health coverage through Tricare.
- 9) You testified you did not have any third-party health insurance outside NYSOH in 2016.
- 10) You testified a representative from NYSOH advised you that NYSOH could be picking up a family member's Tricare enrollment. However, you

testified you were unaware of any family member enrolled in health coverage through Tricare.

- 11) During the hearing, you were directed to submit documentation establishing you were not enrolled in health coverage through Tricare in September 2016. You failed to submit any such documentation.
- 12) You testified you were seeking full Medicaid eligibility and enrollment in a Medicaid Managed Care plan.
- 13) NYSOH Appeals Unit reviewed the recorded telephone calls you made to NYSOH on October 16, 2016 and determined the following:
  - a. You acknowledged you were in receipt of Tricare coverage; however, you claimed it was an entitlement and not insurance.
  - b. You stated you spoke to a representative at Tricare and you were advised you could not terminate your coverage through Tricare because it was an entitlement. You further indicated Tricare was unable to provide you with the documentation requested by NYSOH.
  - c. You indicated you wanted to appeal NYSOH's eligibility determination because you wanted to have coverage through Tricare, a Medicaid Managed Care plan and fee-for-service Medicaid simultaneously.

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

## **Applicable Law and Regulations**

### Medicaid Eligibility

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)).

### Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)). However, if the applicant submits

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an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

### Third Party Health Insurance

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY Social Services Law (NY SSL) § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

### Verification of Minimum Essential Coverage

NYSOH must verify whether an applicant is eligible for minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHIP, or the BHP, using information obtained by transmitting identifying information specified by HHS to HHS for verification purposes (45 CFR § 155.330(b)).

Minimum essential coverage includes most government-sponsored insurance plans such as Medicaid, Medicare, CHIP, Tricare, Veterans' Health Coverage, and eligible employer-sponsored insurance (26 USC § 5000A(f)).

## **Legal Analysis**

The issue is whether NYSOH properly determined you were not eligible to enroll in a Medicaid Managed Care plan.

On September 20, 2016, NYSOH received information from state and federal data sources indicating you were enrolled in health coverage through Tricare as of September 1, 2016.

NYSOH is required to verify whether an applicant is eligible for minimum essential coverage, including Tricare. As a result, you were determined conditionally eligible for fee-for-service Medicaid only, pending receipt of documentation evidencing the termination of your coverage through Tricare. You were not eligible to enroll in a Medicaid Managed Care plan during this conditional eligibility period. Your account indicates you never submitted the requested documentation to NYSOH.

Although you testified you were never enrolled in coverage through Tricare, the state and federal data sources relied upon by NYSOH contradict this testimony. Further contradicting this testimony are statements you made to NYSOH representatives during a series of recorded telephone calls on October 6, 2016 where you acknowledged you had coverage through Tricare, but you claimed it was an entitlement and not insurance. You further stated during these telephone calls that Tricare was unable to provide you with a letter stating your coverage was terminated because you cannot terminate your Tricare coverage. Finally, you indicated to a NYSOH representative on October 6, 2016 that you wanted to have insurance coverage through Tricare, Medicaid and a Medicaid Managed Care plan simultaneously.

Accordingly, given the totality of the evidence, your testimony that you were never enrolled in coverage through Tricare is not credible.

Pursuant to the above cited regulations, a person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan. Most government-sponsored insurance plans, including Tricare, are considered minimum essential coverage.

Federal and state data sources indicated you were enrolled in health coverage through Tricare as of September 1, 2016 and you failed to submit any documentation to contradict this information. Accordingly, the evidence establishes you were enrolled in health coverage through Tricare as of September 1, 2016. As such, you were not permitted to enroll in a Medicaid Managed Care plan.

Therefore, the September 21, 2016 eligibility determination notice finding you conditionally eligible for fee-for-service Medicaid and the notice of enrollment confirmation stating the type of Medicaid coverage you were eligible for did not require/ allow you to enroll in a health plan are correct and are AFFIRMED.

## **Decision**

The September 21, 2016 eligibility determination notice and the notice of enrollment confirmation are AFFIRMED.

**Effective Date of this Decision:** March 23, 2017

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

This decision does not affect your eligibility.

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).

You are not eligible to enroll in a Medicaid Managed Care plan.

## **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  
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 September 21, 2016 eligibility determination notice and the notice of enrollment confirmation are **AFFIRMED**.

This decision does not affect your eligibility.

You are not eligible to enroll in a Medicaid Managed Care plan

## **Legal Authority**

We are sending you this notice 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.

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