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

Notice of Decision

Decision Date: September 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018684

[redacted]

Dear [redacted],

On August 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 4, 2017 verbal denial of Medicaid Premium Assistance Payments.

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: September 29, 2017

NY State of Health Account ID: [redacted]
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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 your family was not eligible for Medicaid Premium Assistance Payments for the period of December 1, 2016 through February 28, 2017?

Procedural History

On September 6, 2016, NYSOH issued a renewal notice stating that you needed to renew your family's coverage through NYSOH. This was because your family's Medicaid coverage through your local Department of Social Services (LDSS) would end on November 30, 2016. The notice stated that you needed to log into your NYSOH account before November 15, 2016 to complete the renewal process for your family.

On November 1, 2016, you submitted your family's initial application for health insurance to NYSOH.

On November 2, 2016, NYSOH issued a notice informing you that additional proof of household income was needed by November 16, 2016. The notice also stated you needed to provide proof of benefit information for Third Party Health Insurance (TPHI) for your family by November 23, 2016.

On November 7, 2016, you submitted proof of TPHI and this documentation was verified on November 22, 2016.

Also on November 7, 2016, you submitted income documentation for your spouse.

On November 9, 2016, NYSOH issued a notice stating that November 8, 2016 updated application had been reviewed, but the household income information you provided did not match what NYSOH had obtained from State and Federal data sources. Therefore, NYSOH was unable to make a determination until you submitted additional income documentation. You had until November 16, 2016 to submit income documentation for your household.

On November 23, 2016, NYSOH issued a notice that the documentation you submitted was reviewed, but it did not confirm the information in your application. You were requested to provide proof of household income by November 16, 2016.

During the months of November 2016 through March 2017, numerous notices were issued by NYSOH stating that income information in your application did not match what NYSOH received from state and federal data sources and additional income information was required to confirm your family member's eligibility.

On April 14, 2017, NYSOH verified the household income documentation you submitted on April 10, 2017, and your family's eligibility was redetermined at that time.

On April 15, 2017, NYSOH issued an eligibility determination notice stating that you and your family were eligible for Medicaid, effective March 1, 2017.

Also on April 15, 2017, NYSOH issued a notice concerning your request for help with paying medical bills for your family for the three-month period prior to your March 24, 2017 updated application. The notice directed you to provide proof of income for your family for the period of December 1, 2016 to February 28, 2017 by April 29, 2017.

On April 25, 2017, NYSOH verified the household income documentation you submitted on April 21, 2017 for the months of December 2016, January 2017 and February 2017.

On April 26, 2017, NYSOH issued an eligibility determination notice stating that you and your family members were eligible for Retroactive Medicaid with coverage in Fee-For-Service for the months of December 2016, January 2017 and February 2017.

On May 4, 2017, you contacted NYSOH's Account Review Unit and inquired on the status of your Medicaid Premium Assistance Payments (PAP) for the period of December 2016, January 2017 and February 2017. On that date, you were verbally advised that NYSOH could not provide Medicaid PAP for the months of

your Retroactive Medicaid coverage. You appealed that verbal determination denying Medicaid PAP for the months of December 2016, January 2017 and February 2017.

On August 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for 15 days to allow you to submit supporting documentation.

That same day, the Appeals Unit received via secure facsimile a Notice of Decision to Pay Third Party Health Insurance Premiums issued by your LDSS, dated October 14, 2016, and a Medicaid Assistance Remittance Statement, dated October 24, 2016. These documents were collectively made part of the record as Appellant's Exhibit #1. The record is now closed.

Findings of Fact

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

1) According to your NYSOH account and your testimony, your family's Medicaid coverage through your LDSS was transitioned to the NYSOH on September 5, 2016.

2) According to your NYSOH account, on September 6, 2016, NYSOH issued a renewal notice advising you of the steps that needed to be taken before your Medicaid coverage through your LDSS ended on November 30, 2016.

3) You testified and submitted documentation to show that your LDSS reimbursed you the cost of your family health insurance premiums for the months of October 2016 and November 2016. The amount the Medicaid PAP program paid was $412.01 per month.

4) According to your testimony and documentation, your family's health insurance coverage is provided by your spouse's employer and [redacted] share of the cost of that coverage is $412.01 per month, which amount is deducted from his pay on a pro-rated weekly basis.

5) According to your NYSOH account and your testimony, you and your family were determined eligible for Medicaid effective March 1, 2017.

6) According to your NYSOH account and your testimony, you and your family were determined eligible for Retroactive Medicaid for the months of December 2016, January 2017 and February 2017.

7) On April 21, 2017, you submitted proof of income for those months and this documentation was verified by NYSOH on April 25, 2017.

8) According to your NYSOH account and your testimony, you have been reimbursed by the Medicaid PAP through NYSOH for your TPHI payments in the amount of $412.01 beginning March 2017 and going forward.

9) According to your NYSOH account and your testimony, you were verbally told by a NYSOH representative on May 4, 2017, that NYSOH could not provide Medicaid PAP for the months your family was determined eligible for Retroactive Medicaid coverage.

10) You testified that you are appealing NYSOH's verbal denial of Medicaid PAP reimbursement for the months of December 2016, January 2017 and February 2017.

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

Applicable Law and Regulations

De Novo Review

NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

Medicaid Premium Reimbursement

The state or local agency administering Medicaid programs must take all reasonable measures to ascertain the legal liability of third parties (Social Security Act § 1902(a)(25); 42 USC. § 1396(a)). Third parties include health insurers, self-insured plans, group health plans, service benefit plans, managed care plans, etc., that are legally responsible for payment of a claim for a health care item or service (42 USC. § 1396(a)).

The Medicaid assistance program will pay the health insurance premiums for personal health insurance covering care and other medical benefits which are authorized under the Medicaid program for cost-effective, employer-sponsored group health insurance benefits. Such premiums can also be paid for the benefit of the recipient's spouse and dependent children (18 NYCRR §360-7.5(g)(1).

The cost-benefit analysis for premiums that is to be relied upon by NY State of Health is performed by the Department of Health's Third Party Resource Unit (13 ADM 03 [Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010], Section III, Subsection I). The unit performs this analysis using a programmed calculator known as HIPP calculator (GIS 13 MA/012 (May 1,

2013)). The determinations of cost effectiveness are subject to appeal (13 ADM 03, Section III, Subsection J).

Legal Analysis

The issue under review is whether the Medicaid PAP program should provide premium assistance for the health insurance that your family payed toward employer-sponsored insurance for the months of December 2016, January 2017 and February 2017.

On May 4, 2017, you spoke with NYSOH's Account Review Unit and inquired on the status of your Medicaid PAP for the period of December 2016, January 2017 and February 2017. On that date, you were verbally advised that NYSOH could not provide PAP for the months your family had Retroactive Medicaid coverage. You appealed that verbal denial of Medicaid PAP for the months of December 2016, January 2017 and February 2017.

The record does not contain a notice of eligibility determination or redetermination on the issue of the denial of Medicaid PAP payments for the period you were determined eligible for Retroactive Medicaid coverage. It does contain a May 5, 2017 notice in which NYSOH acknowledges receipt of an appeal request and identifies the issue on appeal as "Denial of Medicaid Premium Assistance payments."

Here, the lack of a notice of eligibility determination on the issue of the denial of Medicaid PAP does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The text of the May 5, 2017 notice, which acknowledges the appeal on the denial of Medicaid PAP, permits an inference that NYSOH did deny your request for Medicaid PAP during the months your family was determined eligible for Retroactive Medicaid coverage.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the notice of eligibility determination had it been issued. Therefore, the issue under review is whether you were properly denied Medicaid PAP for the months of December 2016, January 2017 and February 2017.

You and your family were receiving Medicaid PAP through your LDSS and were transitioned to NYSOH on September 5, 2016. At that time, NYSOH issued a notice advising you of the transition and the steps you needed to take by November 15, 2016 in order to complete the renewal process.

The record reflects that you submitted your initial application for your family's health insurance on November 1, 2016. The record further reflects that, over the ensuing months, there were numerous submissions on your part of income documentation, proof of employer-sponsored health insurance, and the payments that were being deducted for this insurance from your spouse's weekly paycheck.

You submitted as Appellant's Exhibit #1 as proof that your LDSS had approved Medicaid PAP payments and made those payments to reimburse premiums for October 2016 and November 2016. Those reimbursement payments were $412.01 for each of those months.

The record reflects that on April 15, 2017, NYSOH issued an eligibility determination notice stating that you and your family were eligible for Medicaid, effective March 1, 2017. At that time, NYSOH acknowledged your March 24, 2017 request for help with paying medical bills for your family for the three-month period prior to your March 24, 2017 updated application. You were directed to provide proof of income for your family for the period of December 1, 2016 to February 28, 2017 by April 29, 2017. On April 21, 2017, you submitted proof of income for those months and this documentation was verified by NYSOH on April 25, 2017.

On April 26, 2017, NYSOH issued an eligibility determination notice stating that you and your family members were eligible for Retroactive Medicaid in Fee-For-Service for the months of December 2016, January 2017 and February 2017.

On May 4, 2017, you spoke with NYSOH and inquired on the status of the Medicaid PAP reimbursements you had been receiving prior to the transition of your family from your LDSS to NYSOH. You were informed that your Medicaid PAP reimbursement checks would be issued to cover March 2017 forward, but that NYSOH could not make Medicaid PAP payments for the months your family was determined eligible for Retroactive Medicaid and this appeal ensued.

The Medicaid Assistance Program will pay the health insurance premiums for personal health insurance covering care and other medical benefits which are authorized under the Medicaid program for cost-effective, employer-sponsored group health insurance benefits. Such premiums are also paid for the benefit of the recipient's spouse and dependent children.

The record reflects that your LDSS had approved Medicaid PAP reimbursement in the amount of $412.01 per month for the months of October 2016 and November 2016. Those reimbursement payments were resumed by NYSOH as of March 2017, and are presently continuing on a monthly basis.

The record further reflects that you and your family have been covered continuously in Medicaid Fee-For-Service from October 1, 2016 through the present time, including coverage through Retroactive Medicaid from December 1,

2017 through February 28, 2017, as determined by NYSOH. In addition, after the hearing but before this decision was issued, the Medicaid PAP reviewed your case and determined it would be cost-effective to reimburse you for the premiums for the months of December 2016, January 2017 and February 2017. NYSOH Appeals Unit has been advised by Medicaid PAP that you were notified accordingly. As such, the issue on appeal has been resolved in your favor and your appeal is rendered moot.

Decision

Your family has been determined to qualify for Medicaid PAP reimbursement for health insurance premiums you paid for the months of December 2016, January 2017 and February 2017. Medicaid PAP will reimburse you directly.

The issue on appeal has been resolved in your favor such that your appeal is rendered moot. No further action by NYSOH is required at this time.

Effective Date of this Decision: September 29, 2017

How this Decision Affects Your Eligibility

You and your family were eligible for Medicaid PAP reimbursement for payments you made for employer sponsored insurance for the months of December 2016, January 2017 and February 2017. Medicaid PAP will reimburse you directly.

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

Your family has been determined to qualify for Medicaid PAP reimbursement for health insurance premiums you paid for the months of December 2016, January 2017 and February 2017. Medicaid PAP will reimburse you directly.

The issue on appeal has been resolved in your favor such that your appeal is rendered moot. No further action by NYSOH is required at this time.

You and your family were eligible for Medicaid PAP reimbursement for payments you made for employer sponsored insurance for the months of December 2016, January 2017 and February 2017. Medicaid PAP will reimburse you directly.

Legal Authority

We are issuing this determination in accordance with 45 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).

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)

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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।

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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