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

Notice of Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017691

[redacted]

[redacted],

On July 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 5, 2017 eligibility determination notice and your eligibility for retroactive Medicaid coverage for emergency medical care and services during the month of December 2016.

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: August 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017691

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that your eligibility for Medicaid coverage for emergency medical care and services was effective April 1, 2017?
>
> Were you eligible for retroactive Medicaid coverage for emergency medical care and services during the month of December 2016?

Procedural History

On March 22, 2017, NYSOH received a facsimile from a certified application counselor [redacted], which included a completed Identity Verification Form (DOH-5068 (9/13)) executed by you, and a copy of your high school graduation certification issued by the [redacted].

On April 4, 2017, NYSOH received your application for health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you were eligible for Medicaid coverage for emergency medical care and services only, effective April 1, 2017. The preliminary determination also stated that you qualified for retroactive Medicaid coverage during January, February and March of 2017.

Also on April 4, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the April 4, 2017 preliminary eligibility determination

insofar as you were seeking Retroactive Medicaid coverage for the treatment of emergency medical conditions during the month of December 2016.

On April 5, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid coverage for emergency medical care and services only, effective April 1, 2017.

Also on April 5, 2017, NYSOH issued a notice of eligibility determination stating that you qualified for Retroactive Medicaid coverage during January, February and March of 2017.

On July 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, Spanish Interpreter [redacted] assisted you with your 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) You attested in your April 4, 2017 application to NYSOH that you are single and have no children. You also attested that your expected yearly income would be $0.00 and that your Citizenship/Immigration status was "Other." Finally, you attested that you were seeking help with paying for medical bills incurred during the three months prior to your application.

2) On April 4, 2017, NYSOH prepared a preliminary determination based on the information in that application. You were found eligible for Medicaid coverage for the treatment of emergency medical conditions beginning April 1, 2017. You were also found eligible for retroactive Medicaid coverage for the treatment of emergency medical conditions during January, February and March of 2017.

3) A facsimile containing a completed Identity Verification Form (DOH-5068 (9/13)) executed by your certified application counselor [redacted], and a copy of your high school graduation certification issued by the [redacted] from [redacted] was received by NYSOH on March 22, 2017.

4) You testified that your income during the month of December 2016 was $0.00.

5) You testified that you incurred medical costs from [redacted] in December 2016.

6) You testified that you are seeking Retroactive Medicaid coverage for the treatment of emergency medical conditions during the month of December 2016.

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

Applicable Law and Regulations

Medicaid Coverage

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Medicaid coverage may start retroactively for up to three months prior to the month of application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Immigration Status and Medicaid Eligibility

A person who meets certain non-financial criteria and has a household income that is at or below the applicable Medicaid income standard is eligible for Medicaid benefits (45 CFR § 155.305(c)).

One of the non-financial criteria for Medicaid eligibility is the immigration status of the person applying for health insurance. A person is eligible for Medicaid when his or her immigration status is satisfactory and he or she meets all other requirements for Medicaid.

Legal Analysis

The first issue on appeal is whether NYSOH properly determined that you were eligible to receive Medicaid coverage for the treatment of emergency medical conditions, effective April 1, 2017.

Your initial application was received by NYSOH on April 4, 2017, in which you attested to an annual household income of $0.00. On April 5, 2017, NYSOH issued an eligibility determination based on the information contained in the April 4, 2017 application. Because your application was received on April 4, 2017, you

were properly found eligible for Medicaid coverage for the treatment of emergency medical conditions, effective April 1, 2017.

The second issue under appeal is whether you were eligible for Retroactive Medicaid coverage for emergency medical care and services during the month of December 2016.

A facsimile containing your completed Identity Verification Form (DOH-5068 (9/13)) and a copy of your high school graduation certification issued by the [redacted] was received by NYSOH on March 22, 2017. However, there is no evidence to show, nor did you testify, that an application was completed or even begun prior to April 4, 2017; submission of purported identity documents does not constitute an application.

You were eligible for Retroactive Medicaid coverage for three months prior to the month of the application; that is, no earlier than January 1, 2017.

Therefore, you were not eligible for Retroactive Medicaid coverage for December 2016.

Decision

The April 5, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: August 24, 2017

How this Decision Affects Your Eligibility

You are not eligible for Medicaid for the treatment of emergency medical conditions services for December 2016.

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 April 5, 2017 eligibility determination is AFFIRMED.

You are not eligible for Medicaid for the treatment of emergency medical conditions services for December 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).

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

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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