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

Notice of Decision

Decision Date: March 12, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000026326

Dear ,

On February 27, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's finding that you were eligible for retroactive Medicaid coverage for the period between July 1, 2016 and September 30, 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
  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(b).

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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: March 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026326

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 you were not eligible for Medicaid assistance for July 1, 2016 through September 30, 2016?

Procedural History

On October 25, 2016, NYSOH received an update to your application for financial assistance with health insurance. This application did not request help with paying for medical bills incurred during the three months prior to this application.

On October 26, 2016, NYSOH issued a notice stating that the information contained in your application did not match information NYSOH received from state and federal sources. You were requested to provide additional information to NYSOH by November 9, 2016 so that an appropriate eligibility determination could be issued.

On October 28, 2016 and October 31, 2016, NYSOH received (1) several earnings statements issued to you by your employer, and (2) a letter reflecting that your last day at that employer was October 8, 2016.

On November 9, 2016, NYSOH redetermined your eligibility for financial assistance with health insurance.

On November 10, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective November 1, 2016.

On September 22, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance, in which you were seeking help with paying medical bills incurred during the three months prior to your application.

On December 26, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not found eligible for retroactive Medicaid for the prior between July 1, 2016 and September 30, 2016.

On February 27, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. At your request, a Haitian-Creole interpreter (ID # [redacted] attended the hearing. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You testified that you are seeking Medicaid from July 1, 2016 and September 30, 2016.

2) You testified that you updated your application on October 25, 2016, seeking a determination finding you eligible for Medicaid, but did not request retroactive coverage for the three-month period prior to that application.

3) You were found eligible for Medicaid effective November 1, 2016, which continued until October 31, 2017.

4) You testified that for the period between July 1, 2016 and September 30, 2016, your insurance carrier, United Healthcare (UHC), had been covering the medical bills associated with the various medical procedures during that time.

5) You testified that as late as September 2017, UHC rescinded their coverage of you during the period between July 1, 2016 and September 30, 2016, and clawed back amounts paid to your various providers for your medical care. You further testified that since this time, your providers then billed you for those outstanding amounts totaling approximately $14,000.00.

6) You testified that you did not request retroactive coverage for the period between July 1, 2016 and September 30, 2016 since you understood yourself to be covered during that period.

7) You testified, and the record reflects, that you first contacted NYSOH to appeal your Medicaid eligibility for this period until NYSOH redetermined your eligibility on December 20, 2017.

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

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

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)).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial 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 USCA § 1396A(34); 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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for July 1, 2016 and September 30, 2016.

You submitted your initial application for Medicaid on October 25, 2016. Based on the information contained in that application, and the documentation your provided to NYSOH between October 28, 2016 and October 31, 2016, NYSOH issued an eligibility determination notice on November 10, 2016, stating that you were eligible for Medicaid effective November 1, 2016.

The application you provided to NYSOH on October 25, 2016 did not request retroactive coverage for the three-month period prior to that application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied; provided, however, the Appellant must have requested the retroactive coverage within that application.

Since the record reflects that you did not request retroactive coverage at that time, NYSOH properly did not issue an eligibility notice with respect to your eligibility for retroactive Medicaid coverage.

Accordingly, we find that NYSOH properly determined that you were not found eligible for retroactive Medicaid coverage for the period between July 1, 2016 and September 30, 2016, and the NYSOH's actions with respect to this finding are AFFIRMED.

Decision

NYSOH properly determined that you were not found eligible for retroactive Medicaid coverage for the period between July 1, 2016 and September 30, 2016, and so is AFFIRMED.

Effective Date of this Decision: March 12, 2018

How this Decision Affects Your Eligibility

You are not eligible for retroactive Medicaid for the period between July 1, 2016 and September 30, 2016.

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 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 case 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):

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
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

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Summary

NYSOH properly determined that you were not found eligible for retroactive Medicaid coverage for the period between July 1, 2016 and September 30, 2016, and so is AFFIRMED.

You are not eligible for retroactive Medicaid for the period between July 1, 2016 and September 30, 2016.

Legal Authority

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

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A Copy of this Decision Has Been Provided To:

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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)

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 महत्त्वपूर्ण 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 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.

(Urdu)اردو

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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