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

Notice of Decision

Decision Date: March 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026737

[redacted]

Dear [redacted],

On March 6, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of retroactive Medicaid for the month of August 2017.

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 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.

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: March 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026737

[redacted]

Issue

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

> Did NY State of Health properly determine that you were not eligible for retroactive Medicaid from August 1, 2017 through August 31, 2017?

Procedural History

According to your NY State of Health (NYSOH) account, you were found eligible for and enrolled in a gold level qualified health plan as of March 1, 2017. You next updated your account on December 7, 2017, and pursuant to NYSOH's request, you submitted proof of income (*see* Document [redacted]). That proof was validated by NYSOH on December 27, 2017

On December 28, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective December 1, 2017. This was because your household income of $2,550.00 was below the allowable income limit for Medicaid.

Also on December 28, 2017, NYSOH issued a second eligibility determination notice stating that you were eligible for retroactive Medicaid, effective September 1, 2017 through November 30, 2017.

On January 3, 2018, you spoke to NYSOH's Account Review Unit and appealed not being eligible for retroactive Medicaid for more than three months; specifically, for the month of August 2017.

On January 4, 2018, NYSOH issued a notice confirming your appeal of an "Eligibility Determination."

On March 6, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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 were initially found eligible for retroactive Medicaid as of September 1, 2017.

2) You testified that you are also seeking retroactive Medicaid coverage for the month of August 2017.

3) According to your NYSOH account and testimony, you initially updated your account and applied for Medicaid on December 7, 2017. A review of your file does not indicate any prior applications or duplicate accounts.

4) You testified that you would have applied for Medicaid sooner but no one at the hospital advised you that you could.

5) You testified that although you were covered by your gold-level qualified health plan in the month of August 2017, it did not cover all your medical bills.

6) At all times relevant, you were [redacted].

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

Applicable Law and Regulations

<u>De Novo Review</u>

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).

Retroactive Medicaid for Adults between the Ages of 19 and 65

The Department of Health must make Medicaid coverage 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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for retroactive Medicaid from August 1, 2017 through August 31, 2017.

The record reflects that you updated your account and applied for Medicaid for yourself on December 7, 2017. On December 28, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective December 1, 2017.

Although the record contains a December 28, 2017 eligibility determination notice on the issue of Medicaid eligibility for the months of September 2017 through November 2017, it is silent as to your request for retroactive Medicaid coverage for the month of August 2017. The record does contain evidence of a January 4, 2018 notice in which NYSOH acknowledges receipt of an appeal request, and identifies you as the appellant and the issue on appeal as “Eligibility Determination.”

Here, the lack of a notice of eligibility determination on the issue of retroactive Medicaid for you for the month of August 2017 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 January 4, 2018 notice, which acknowledges the appeal on the issue of your eligibility determination, along with your testimony, in which you stated you wanted help covering the medical expenses you have for the month of August 2017, permits an inference that the NYSOH did not determined your eligibility for retroactive Medicaid in the month of August 2017.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to an eligibility determination had it been issued.

You were initially found eligible for retroactive Medicaid in the December 28, 2017 eligibility determination notice. According to this notice, your coverage with retroactive Medicaid began September 1, 2017.

You testified that you are also seeking to have your Medicaid coverage retroactively applied for the month of August 2017.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's 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.

According to your NYSOH account and testimony, you initially updated your account and applied for Medicaid on December 7, 2017. A review of your NYSOH account and its system does not indicate there were any applications or duplicate accounts before December 7, 2017.

However, you testified that you would have applied sooner, but no one at the hospital advised you that you could. Nonetheless, the hospital's failure to advise you to apply for Medicaid and your failure to do so in a timely manner, is not an error or mistake attributable to NYSOH, it agents or instrumentalities.

Since you initially applied through NYSOH on December 7, 2017, and Medicaid can only be applied retroactively for up to three months prior to that application, or from September 1, 2017, your Medicaid coverage cannot be retroactively applied to August 2017, which is four months prior to your initial December 7, 2017 application.

Therefore, by this decision, it is determined that you were not eligible for retroactive Medicaid in the month of August 2017.

Decision

By this decision, it is determined that you were not eligible for retroactive Medicaid in the month of August 2017.

Effective Date of this Decision: March 9, 2018

How this Decision Affects Your Eligibility

You were not eligible for retroactive Medicaid in the month of August 2017.

Your eligibility for retroactive Medicaid was effective as of September 1, 2017.

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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

By this decision, it is determined that you were not eligible for retroactive Medicaid in the month of August 2017.

You were not eligible for retroactive Medicaid in the month of August 2017.

Your eligibility for retroactive Medicaid was effective as of September 1, 2017.

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.

□□□ (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)

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).

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 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.

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)

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).

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.

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).