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

Notice of Decision

Decision Date: April 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026880

[redacted]

On April 9, 2018, you appeared by telephone, with the assistance of a Spanish Interpreter (ID #[redacted], at a hearing on your appeal of NY State of Health's January 4, 2018 denial of your request for retroactive Medicaid for the month of September 2017 for your grandchild.

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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: April 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026880

[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 that your grandchild was not eligible for retroactive Medicaid for September 1, 2017 through September 30, 2017?

Procedural History

According to your NYSOH account, you updated your account and added your youngest grandchild (grandchild) to your application for financial assistance on January 3, 2018. The next day, your grandchild was enrolled in Medicaid Fee-For Service retroactively for the period of October 1, 2017 through December 31, 2017.

On January 4, 2018, NYSOH issued an eligibility determination notice, based on your January 3, 2018 application, stating that your grandchild remained eligible for Medicaid, effective January 1, 2018.

On January 8, 2018, you spoke to NYSOH's Account Review Unit and appealed your grandchild not being eligible for retroactive Medicaid for more than three months; specifically, for the month of September 2017.

On January 9, 2018, NYSOH issued a notice confirming your grandchild as the appellant and your appeal of her "Eligibility determination."

On April 9, 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) According to your NYSOH account and testimony, your grandchild was initially added to your NYSOH account on January 3, 2018, and found eligible for Medicaid as of January 1, 2018. You testified that you are seeking retroactive Medicaid coverage for your grandchild for the month of September 2017.

2) Your grandchild's Enrollment History Tab shows that she was granted retroactive Medicaid coverage for the previous three months from October 2017 through December 2017.

3) You testified that you require health coverage for your grandchild for September 2017, because there are outstanding medical bills for that month.

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).

<u>Retroactive Medicaid for Adults between the Ages of 19 and 65</u>

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 your grandchild was not eligible for retroactive Medicaid from September 1, 2017 through September 30, 2017.

According to your NYSOH account and testimony, your grandchild was initially added to your NYSOH account on January 3, 2018, and found eligible for Medicaid as of January 1, 2018.

Although the record contains a January 4, 2018 eligibility determination notice on the issue of Medicaid eligibility for January 2018, it is silent as to your request for retroactive Medicaid coverage for the month of September 2017. The record does contain evidence of a January 9, 2018 notice in which NYSOH acknowledges receipt of an appeal request, and identifies your grandchild 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 September 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 9, 2018 notice, which acknowledges the appeal on the issue of your grandchild’s eligibility determination, along with your testimony, in which you stated you wanted help covering the medical expenses for your grandchild for the month of September 2017, permits an inference that the NYSOH did deny your request for retroactive Medicaid in the month of September 2017 for your grandchild.

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.

Your grandchild was initially found eligible for Medicaid as of January 1, 2018, as stated in the January 4, 2018 eligibility determination notice. Additionally, your grandchild’s Enrollment History Tab shows that your grandchild was granted retroactive Medicaid coverage for the months of October 2017 through December 2017.

You testified that you are seeking to have your grandchild’s Medicaid coverage retroactively applied to the month of September 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, your grandchild was initially added to your NYSOH account on January 3, 2018 and found eligible for Medicaid as of January 1, 2018.

Since you initially applied for your grandchild through NYSOH on January 3, 2018, Medicaid can only be applied retroactively for up to three months prior to that application, or from October 1, 2017 through December 31, 2017, which was granted. Therefore, your grandchild's Medicaid coverage cannot be retroactively applied to September 2017, which is four months prior to your initial January 3, 2018 application.

Therefore, by this decision, it is determined that your grandchild was not eligible for retroactive Medicaid in the month of September 2017.

Decision

By this decision, it is determined that your grandchild was not eligible for retroactive Medicaid in the month of September 2017.

Effective Date of this Decision: April 20, 2018

How this Decision Affects Your Eligibility

Your grandchild was not eligible for retroactive Medicaid in the month of September 2017.

Your grandchild's eligibility for Medicaid was effective as of January 1, 2018, with coverage retroactively applied as of October 1, 2017 through December 31, 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
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

By this decision, it is determined that your grandchild was not eligible for retroactive Medicaid in the month of September 2017.

Your grandchild was not eligible for retroactive Medicaid in the month of September 2017.

Your grandchild's eligibility for Medicaid was effective as of January 1, 2018, with coverage retroactively applied as of October 1, 2017 through December 31, 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.

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)

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)

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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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