

**OTHER ELIGIBILITY REQUIREMENTS  
RETROACTIVE ELIGIBILITY PERIOD**

**REIMBURSEMENT OF PAID MEDICAL BILLS**

**Description:** Reimbursement of paid medical expenses may be made to Medicaid recipients or their representatives for covered care and services obtained during the recipients' retroactive eligibility periods (pre and post -application periods).

**Policy:** Social services districts must reimburse, at the Medicaid rate, Medicaid eligible individuals or their representative for qualifying medical expenses paid during the three-month retroactive eligibility period.

Direct reimbursement is not limited to the Medicaid rate or fee in instances where agency error or delay caused the recipient or the recipient's representative to pay for medical services which should have been paid under the Medicaid program.

**NOTE:** Social Services districts have the option of reimbursing eligible recipients directly or requesting the Department to make payments for expenses that the district has determined to be reimburseable.

**References:** ADM            10 OHIP/ADM-9  
  
Dept. Regs.    18 NYCRR 360-7.5 (a)  
  
GISs            03 MA/025  
                    03 MA/019  
                    02 MA/033  
                    98 MA/011  
                    95 MA/032

New York State Fiscal Reference Manual, Volume 1 Chapter 7 and Volume 2 Chapter 5

**Interpretation:** Reimbursement for paid medical expenses is limited to the Medicaid rate, after application of ALL third party reimbursement, unless there was an agency error or delay which caused the recipient or his/her representative to pay for medical services that should have been paid by the Medicaid Program.

Because Family Health Plus benefits do not begin until eligibility is determined AND enrollment in a plan has occurred, there is no reimbursement available under the FHPlus program during the three-month retroactive period. However, individuals who are otherwise eligible under the Medicaid spenddown program during the three-month retroactive period through the date of enrollment in a FHPlus

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plan may be reimbursed for paid expenses in excess of their Medicaid spenddown.

#### **Retroactive Period:**

Reimbursement may be made to a Medicaid eligible individual or his/her representative for paid bills that are:

- incurred during the **retroactive** eligibility period, which begins on the first day of the third month prior to the month in which the individual applied for Medicaid and ends on the date the individual applies for Medicaid;
- medically necessary;
- covered by the Medicaid Program;
- within Medicaid requirements for amount duration and scope; and,
- received from providers lawfully permitted under State law or regulation to provide the care, services or supplies for which the recipient is requesting reimbursement and who has not be excluded by the Medicaid Program.

#### **Post-Retroactive Period:**

Reimbursement may be made to a Medicaid eligible individual or his/her representative for paid bills that are:

- incurred during the **post-retroactive** eligibility period, which begins on the date of application and ends on the date the individual receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope; and,
- provided by Medicaid enrolled providers.

**NOTE:** For new SSI recipients, reimbursement for paid medical expenses beginning three months prior to the month of application and ending on the day the recipient receives the "Dear SSI Beneficiary" letter must NOT be limited to expenses incurred from providers enrolled in the Medicaid program.

#### **Agency Delay:**

Reimbursement may be made to a Medicaid eligible individual or his/her representative for bills that are paid as a result of an LDDS's delay and are:

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- incurred beginning 45 days after the date of application and before the receipt of a CBIC card; or
- incurred beginning 30 days after the date of application when the application includes a pregnant woman or child under the age of 19 and before the receipt of a CBIC card; or
- incurred beginning 90 days after the date of application when the application is based on disability and before receipt of a CBIC card; and
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope; and,
- received from providers lawfully permitted under State law or regulation to provide the care, services or supplies for which the recipient is requesting reimbursement and who has not be excluded by the Medicaid Program.

**FHPlus:** After eligibility for FHPlus has been determined, the agency must process the plan enrollment by the 45<sup>th</sup> day following the eligibility decision if the decision was timely. If the decision was made after the proper timeframe, the agency must process the plan enrollment by the 45<sup>th</sup> day following the day the decision should have been made. When enrollment does not occur within these timeframes, the applicant is entitled to be reimbursed for reasonable out-of-pocket expenses paid from day 45 to the date enrollment is actually effective.

### **Agency Error:**

Reimbursement may be made to a Medicaid eligible individual or his/her representative for bills that are paid as a result of an LDSS's error and are:

- incurred from the date of the social services district's incorrect determination until the date the applicant receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program;
- within Medicaid requirements for amount duration and scope; and,
- received from providers lawfully permitted under State law or regulation to provide the care, services or supplies for which the recipient is requesting reimbursement and who has not been excluded by the Medicaid Program.

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**NOTE:** Reimbursement may also be available when, due to social services district delay in the provision of authorized services such as personal care services, the recipient or the recipient's representative must pay privately to obtain covered services.

**FHPlus:** For individuals determined eligible for FHPlus, such recipient or his/her representative may be reimbursed for reasonable out-of-pocket expenses (as defined below) paid after the date of the agency's error (as found on the Notice of Decision) through the day the individual's FHPlus enrollment is effective. The services must be those that are covered under the FHPlus plan and must be provided by an entity or individual lawfully permitted to provide the care, services or supplies for which the recipient is requesting reimbursement.

Reimbursement in cases of agency error or delay must be made for reasonable out-of-pocket expenditures. Generally, out-of-pocket expenditures that do not exceed 110% of the Medicaid rate are always considered reasonable and may be fully reimbursed. In some instances out-of-pocket expenses that exceed this threshold may be considered reasonable if the recipient or his/her representative can demonstrate and document that the services cost more due to living in a remote location or purchasing services on a holiday or other special circumstance. In such situations, reimbursement of full-out-of pocket expenses may be warranted.

To obtain reimbursement for bills paid during the retroactive periods, the recipient must document income and resources, as appropriate, in order for eligibility to be determined for the appropriate retroactive period. In all circumstances, proof that the bills for which direct reimbursement is sought were paid must be provided. Claims not supported by proof of payment with documentation such as cancelled checks or notarized affidavits are not reimbursable.

**NOTE:** Once a CBIC card is received, NO reimbursement may be made for expenses incurred after that date and paid by a recipient.

Social services districts must provide information concerning the policy for direct reimbursement of medical expenses to all Medicaid/FHPlus applicants, including those who apply at outreach sites and to all Temporary Assistance applicants who also apply for Medicaid. The provision of the LDSS-4148B: "What You Should Know About Social Services Programs" to such applicants fulfills this requirement.