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

Notice of Decision

Decision Date: February 07, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024864

On January 22, 2018, you appeared by telephone, with your Authorized Representative representing you, at a hearing regarding your request for retroactive Medicaid coverage for the month of July 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 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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: February 07, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000024864

Issue

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

> Are you eligible for retroactive Medicaid assistance for the month of July 2017?

Procedural History

On November 14, 2017, you applied through NYSOH for financial assistance with health insurance including requesting assistance paying for medical bills for the last three months.

On November 15, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for a full cost qualified health plan, Effective December 1, 2017.

Also on November 15, 2017, NYSOH issued a notice stating that you and your daughter were not eligible for retroactive Medicaid coverage for the month of August 2017 because your household income of $4,840.34 was over the allowable monthly limit.

On November 27, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you unsuccessfully attempted, in August 2017, to request help for payment of medical bills and you are seeking retroactive Medicaid coverage for July 2017.

On January 22, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, your Authorized Representative

█████ assisted you with your testimony. The record was developed during the hearing and held open until January 29, 2018 for you to provide income documentation.

Also on January 22, 2017, you faxed income documentation to the NYSOH Appeals Unit which was made part of the record as "Appellant's Exhibit 1."

On January 26, 2018, you faxed additional income documentation to the NYSOH Appeals Unit which was added to the record as "Appellant's Exhibit 1." The record was closed that day.

Findings of Fact

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

1) Your Authorized Representative, and certified application counselor, testified that she attempted, online, to apply for financial assistance on your household's behalf on August 8, 2017.

2) Your Authorized Representative testified that on August 8, 2017 she was unable to submit your application for a determination of your household's eligibility because an online message displayed stating that the marketplace was having technical difficulties.

3) Your Authorized Representative testified that in August 2017 she attempted to call NYSOH and a representative advised her to wait 24 to 48 hours and to try again.

4) NYSOH records reflect calls made from your certified application counselor to NYSOH, during August 2017, regarding the inability to complete an application due to a system defect.

5) Your Authorized Representative testified that she unsuccessfully attempted numerous times to apply for your household and in late August 2017 she emailed the NYS Health Insurance Program – Medicaid Eligibility Part for assistance with your application.

6) Your Authorized Representative testified that she called NYSOH several times in September 2017 regarding the inability to apply and was advised that there was nothing that could be done.

7) Your Authorized Representative testified that in October 2017 she continued attempts to apply on your household's behalf online, but received the same technical difficulty messages.

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8) Your Authorized Representative testified that she called NYSOH at the end of October 2017 and was advised by a NYSOH representative that she should start a new NYSOH account under your spouse's name and under a different account number.

9) Your Authorized Representative testified, and NYSOH records reflect that [redacted] was created on November 13, 2018.

10) You testified that you were in communications with your Authorized Representative/certified application counselor during August 2017 through November 2017 regarding the difficulties incurred while attempting to apply on your household's behalf.

11) NYSOH records reflect that the first application for 2017 was submitted on your household's behalf on November 13, 2017.

12) You and your Authorized Representative testified that you should be eligible for retroactive Medicaid for July 2017 because, through no fault of your own, you were unable to apply to NYSOH in August 2017 and ask for help paying for medical bills.

13) Your Authorized Representative testified that you are seeking retroactive Medicaid coverage for yourself for the month of July 2017.

14) You testified that you are married and that your spouse lives with you.

15) You testified that you and your spouse are self-employed.

16) You testified that you and your spouse had no income during July 2017.

17) You testified that you were hospitalized from [redacted] through [redacted] and have medical bills from that month.

18) NYSOH records do not reflect that a determination was rendered with respect to retroactive Medicaid for the month of July 2017.

19) On January 22, 2017, you faxed to the NYSOH Appeals Unit an attestation stating that you and your spouse had $0.00 in gross income for the month of July 2017.

20) On January 26, 2017, you faxed to the NYSOH Appeals Unit a letter from your daughter's employer, [redacted], stating that your daughter had $0.00 in gross income for the month of July 2017.

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

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Applicable Law and Regulations

Medicaid

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)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $20,420.00 for a three-person household (81 Federal Register 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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 is whether you were eligible for retroactive Medicaid coverage for the month of July 2017.

On November 14, 2017, you updated your application including requesting assistance paying for medical bills for the months the prior three months.

However, your Authorized Representative (and certified application counselor) testified that on August 8, 2017, she attempted, on your household's behalf, to submit an application and seek assistance paying for medical bills for the prior three months, but was unable to do so. She testified that she continuously

received online messages in August 2017 stating that marketplace was having technical difficulties. She attempted to call NYSOH and a representative advised her to wait 24 to 48 hours and to try again.

NYSOH records reflect calls made from your certified application counselor to NYSOH, during August 2017, regarding the inability to complete an application due to a system defect.

Your Authorized Representative testified that she unsuccessfully attempted numerous times to submit an application, online, for your household and in late August 2017 as well as emailed the NYS Health Insurance Program – Medicaid Eligibility Part for assistance with your application.

Your Authorized Representative testified that she continued attempts to apply on your household's behalf online, but received the same technical difficulty messages. She also testified that she created a new account to try and correct the problem.

You testified that you were in communications with your Authorized Representative/certified application counselor during August 2017 through November 2017 regarding the difficulties she incurred while attempting to apply for health insurance on your household's behalf.

Based on the above, the Appeal's Unit finds the testimony of your Authorized Representative to be credible regarding her efforts to submit an application on your household's behalf during August 2017, and that NYSOH improperly failed to allow your application to be completed.

As such, you should have been able to request help for the payment of medical bills (in August 2017) for retroactive Medicaid coverage for the month of July 2017.

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.

You are in a three-person household.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in July 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,349.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during July 2017.

You testified that you had $0.00 in household income in July 2017. On January 22, 2017, you faxed income information consisting of an attestation stating that you and your spouse had $0.00 in gross income for the month of July 2017. Also, on January 26, 2017, you faxed a letter from your daughter's employer, [redacted] stating that your daughter had $0.00 in gross income for the month of July 2017.

Since your income of $0.00 was less than the $2,349.00 monthly Medicaid limit for July 2017, NYSOH should have determined that you were eligible for Medicaid coverage during that month.

Therefore, your case is being RETURNED to NYSOH to reinstate your Medicaid coverage for the month of July 2017.

Decision

You were eligible for retroactive Medicaid for the month of July 2017.

Your case is being RETURNED to NYSOH to reinstate your Medicaid coverage for the month of July 2017.

Effective Date of this Decision: February 07, 2018

How this Decision Affects Your Eligibility

Your case is being RETURNED to NYSOH to reinstate your Medicaid coverage for the month of July 2017.

You were eligible for retroactive Medicaid for the month of July 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

Your case is being RETURNED to NYSOH to reinstate your Medicaid coverage for the month of July 2017.

You were eligible for retroactive Medicaid for the month of July 2017.

Legal Authority

We are issuing this determination in accordance with 45 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).

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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