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

Notice of Decision

Decision Date: November 13, 2015

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000003334

[redacted]

Dear [redacted],

On July 20, 2015, your Authorized Representative appeared on your behalf by telephone at a hearing on your appeal of NY State of Health Marketplace's June 6, 2015 eligibility determination.

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 at the top of this notice.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation (CFR) 45 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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Decision

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NY State of Health Number: [redacted]
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Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did the Marketplace properly determine, in the notice of eligibility determination issued on July 2, 2015, that you were no longer eligible for MAGI-based Medicaid, effective July 1, 2015, but that your coverage through the Marketplace would continue until September 30, 2015?
>
> Should your application for health insurance be referred to your local social services agency?
>
> Are you eligible for continuous Medicaid coverage through the Marketplace until your local social services agency issues a determination?

Procedural History

On July 12, 2014, an eligibility determination notice was issued stating that you were eligible for Medicaid because your household income of $0.00 was at or below the allowable income limit. This eligibility was effective July 1, 2014.

On May 15, 2015, the Marketplace issued a notice stating that it was time for you to renew your health insurance. That notice stated that information from federal and state sources showed your income was between $16,105.00 and $46,680.00 and you therefore qualified for a tax credit of up to $217.29 per month and help paying for your share of out-of-pocket costs. However, you were not eligible for Medicaid. This eligibility was effective July 1, 2015. The notice further stated that if the Marketplace had made a mistake you needed to update your account

between May 16, 2015 and June 15, 2015 for the changes to be effective July 1, 2015.

The Marketplace received your updated application for health insurance on June 5, 2015, in which you attested to an expected annual household income of $20,556.00. The Marketplace prepared a preliminary eligibility determination stating that stated you were eligible to receive an advance premium tax credit of up to $283.00 per month, as well as cost-sharing reductions.

Also on June 5, 2015, you contacted the Marketplace's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to the Marketplace's failure to transfer your application for health insurance to your local social services agency for consideration, and its failure to automatically continue your Medicaid eligibility until your local social services agency rendered a determination.

On June 6, 2015, the Marketplace issued a notice of eligibility determination based on the information contained in the June 5, 2015 application. It stated that you were eligible to receive an advance premium tax credit of up to $283.00 per month and, if you selected a silver-level qualified health plan, for cost-sharing reductions. It further stated that you were not eligible for Medicaid because your household income of $20,556.00 was over the allowable income limit. This eligibility was effective July 1, 2015.

Prior to the scheduled hearing, you provided supporting evidence, which included:

- A copy of the July 12, 2014 notice of eligibility determination issued by the Marketplace (Appellant's Exhibit 1)

- A copy of your Social Security Administration Notice of Award, dated October 24, 2014 (Appellant's Exhibit 2)

- A selection from the New York State of Health Evidence Packet, representing application for health insurance as of June 9, 2015 (Appellant's Exhibit 3)

- A copy of the June 6, 2015 notice of eligibility determination issued by the Marketplace (Appellant's Exhibit 4)

- A copy of 14/2014 LCM-02, "Medicaid Recipients Transferred at Renewal from New York State of Health to Local Departments of Social Services," issued on December 1, 2014 to Local District Commissioners (Appellant's Exhibit 5)

- A letter brief in support of your position and a completed Authorized Representative form designating [redacted] as your Authorized Representative.

These documents were marked accordingly and incorporated into the record.

On July 20, 2015, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit. At that time, you confirmed that you would like your Authorized Representative to appear on your behalf. Your Authorized Representative, [redacted], was subsequently sworn in and appeared on your behalf. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

1) You first became eligible for Medicaid through the Marketplace on July 12, 2014 based in part on an attested income of $0.00.

2) The record reflects that you updated your application for health insurance on June 5, 2015. According to this application, you expected to file your 2015 federal income tax return as single and claim no dependents (Appellant's Exhibit 3). The application further reflects that you attested to an expected household income of $20,556.00, which was listed as "Title II" income (*id.*). The same application reflects that you selected "No" when asked if you were certified disabled or chronically ill (*id.*).

3) You contend that New York State of Health (NYSOH) was "on notice" that you were receiving Social Security Disability benefits, making you "financially ineligible for MAGI Medicaid and categorically eligible for non-MAGI Medicaid" (Appellant's Exhibit 6). Testimony was further presented that NYSOH was "on notice" that you were certified disabled because your income source was listed as "Title II" income.

4) Testimony was presented that you were certified as disabled in January 2015, and began receiving disability payments on or around January 2, 2015. According to the Social Security Notice of Award issued on October 24, 2014, you were certified disabled on June 9, 2014, and were entitled to a monthly benefit of $1,684.00 beginning December 2014 (Appellant's Exhibit 2).

5) Testimony was presented that you did not notify the Marketplace of any life changes, including becoming certified disabled.

6) Testimony was presented that you have submitted an application for health insurance through your local Human Resources Administration (HRA).

7) According to 14/2014 LCM-02, "certain individuals will be identified for a referral to the local district for a re-determination of eligibility under non-MAGI eligibility rules…Individuals who respond to a manual renewal,…, who elect to have eligibility determined on a non-MAGI basis will be referred. Individuals who are being manually renewed who are no longer MAGI eligible due to the receipt of Medicare, will be automatically referred to the district for re-determination of eligibility" (Appellant's Exhibit 5, emphasis added).

8) According to 14/2014 LCM-02, certain groups of MAGI-ineligible individuals who should be transferred from NYSOH to the LDSS include "[i]ndividuals who are 19 years old or older, who say they are disabled or chronically ill, who are no longer financially eligible for Medicaid" (Appellant's Exhibit 5, emphasis added).

9) According to 14/2014 LCM-02, when processing referrals from NYSOH, local departments are instructed to open a case on the Welfare Management System (WMS) and provide coverage identical to what a recipient had through the Marketplace (Appellant's Exhibit 5, emphasis added). For New York City recipients, renewal referrals "will be processed systematically through the Eligibility Data and Image Transfer System (EDITS) to provide recipients with uninterrupted coverage until the case is renewed in WMS. These cases will have coverage extended for five months" (*id.*). Furthermore, "eMedNY will continue to hold NYSOH responsible for any Medicaid claims for individuals in Fee for Service (FFS) Medicaid for the month of referral. The following month, eMedNY will shift responsibility to the Fee-for-Service WMS coverage" (*id.*, emphasis added).

10) You are requesting that NYSOH transfer your application to your local HRA, and are further requesting to receive five months of continuous Medicaid coverage.

11) You reside in Richmond County, New York, which is a Human Resources Administration (HRA)-serviced region.

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

Applicable Law and Regulations

MAGI-based Medicaid

There are two primary places to apply for Medicaid in New York State, the New York State of Health Marketplace and your Local Department of Social Services (LDSS) or, if you live in one of New York City's five boroughs, the New York City Human Resources Administration (HRA). Generally, healthy adults aged 19 to 64 apply for Medicaid through the Marketplace, and adults over the age of 65 who are not parents or caretaker relatives apply for Medicaid through their LDSS or the HRA.

An individual is eligible for enrollment in Medicaid through the Marketplace (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

Medicaid can be provided through the Marketplace 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)), N.Y. Soc. Serv. 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 2015 FPL, which is $11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

Non-MAGI-based Medicaid

MAGI methodologies do not apply to individuals in non-MAGI eligibility groups, which include Aged, Blind, and Disabled Medicaid eligibility categories (42 USC § 1396a(e)(14)(D)).

Individuals with disabilities who receive Social Security Disability Insurance (SSDI) benefits may be eligible for Medicaid under a MAGI-based category, or on a Non-MAGI-based category of Aged, Blind, or Disabled (Medically Needy).

An applicant is medically needy if her net available resources do not meet the cost of necessary medical care and services available under the Medicaid program, and she is a person who is certified blind or disabled.

For individuals who are in the Aged, Blind, and Disabled eligibility category, and who have MAGI-based income above the MAGI-Medicaid threshold, non-MAGI-based Medicaid may be provided to individuals who: (1) are under age 65, (2) are not eligible for and enrolled for mandatory coverage, (3) are not otherwise enrolled for optional coverage, and (4) have a household that exceeds 133% of the FPL for the applicable family size (42 CFR § 435.218(b)(1)).

Annual Eligibility Redetermination

With few exceptions, the Marketplace must redetermine eligibility for financial assistance to help pay for health insurance of a qualified individual on an annual basis (45 CFR § 155.335(a)).

For individuals whose Medicaid eligibility is based on MAGI, their financial eligibility must be renewed once every 12 months, and no more frequently (42 CFR § 435.916(a)(1)). However, if the Marketplace receives information about a change in a beneficiary's circumstances that may affect eligibility, it must promptly redetermine that individual's eligibility (42 CFR § 435.916(d)(1)).

Legal Analysis

The first matter at issue is whether the Marketplace properly determined that you were no longer eligible for modified adjusted gross income (MAGI)-based Medicaid.

MAGI-Medicaid can be provided through the Marketplace to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household MAGI that is at or below 138% of the federal poverty level (FPL) for the applicable family size.

The application that was submitted on June 5, 2015 listed an annual household income of $20,556.00 from "Title II" benefits and the eligibility determination relied upon that information.

You expect to file your 2015 federal income tax return as single and claim no dependents on that tax return; therefore, you are in a one-person household.

On the date of your application, the relevant FPL was $11,770.00 for a one-person household. Since $20,556.00 is 174.65% of the 2015 FPL, the Marketplace properly found you to be ineligible for MAGI-Medicaid, using the information provided in your application.

Therefore, the June 6, 2015 notice of eligibility determination is AFFIRMED.

The second matter at issue is whether your application for health insurance should have been automatically referred to your local social services agency.

On May 15, 2015, the Marketplace issued a renewal notice stating that federal and state sources show your income was between $16,105.00 and $46,680.00 and, therefore, you were eligible for tax credits and cost-sharing reductions, but not eligible for Medicaid. You were further requested to update your account if "anything has changed in your life that would affect how you are covered and what you pay for health insurance."

Your application was updated on June 5, 2015, and you were determined ineligible for Medicaid because your household income of $20,556.00 was over the allowable income limit. This application did not indicate that you were certified disabled.

Medicaid is available through the Marketplace to people who meet specific financial and nonfinancial criteria. However, individuals who receive Social Security Disability Insurance (SSDI) payments may be determined through MAGI-based or non-MAGI-based methodologies.

You contend that the Marketplace was put "on notice" that you were certified disabled because your June 5, 2015 application listed $20,556.00 in "Title II" benefits as your only source of income, therefore making you "financially ineligible for MAGI Medicaid and categorically eligible for non-MAGI Medicaid" (Appellant's Exhibit 6). However, it must be noted that there are several categories of Social Security benefits available to a person under "Title II," not all of which require the claimant to be disabled. Such benefits include, but are not limited to, survivors insurance benefit payments.

You provided evidence that you were certified disabled by the Social Security Administration on June 9, 2014, as indicated in the Notice of Award issued on October 24, 2014 (Appellant's Exhibit 2). However, the record reflects, and testimony was further presented, that you did not notify the Marketplace of the change in your life that would affect your eligibility.

Since you did not notify the Marketplace of your disability, and your income was listed as "Title II" income, the Marketplace was unable to determine that you were certified disabled at the time of your May 15, 2015 renewal or June 5, 2015 application.

Therefore, the Marketplace was not obligated at that time to refer your case to the local Social Services provider.

The third matter under review is whether you are eligible for five months of continuous Medicaid coverage through the Marketplace until your local HRA issues an eligibility determination.

According to 14/2014 LCM-02, when processing referrals from the Marketplace, local departments are instructed to open a case on the Welfare Management System (WMS) and provide coverage identical to what a recipient had through the Marketplace (Appellant's Exhibit 5, emphasis added). For New York City recipients, renewal referrals "will be processed systematically through the Eligibility Data and Image Transfer System (EDITS) to provide recipients with uninterrupted coverage until the case is renewed in WMS. These cases will have coverage extended for five months" (i*d.*). Furthermore, "eMedNY will continue to hold NYSOH responsible for any Medicaid claims for individuals in Fee for Service (FFS) Medicaid for the month of referral. The following month, eMedNY will shift responsibility to the Fee-for-Service WMS coverage" (*id.*, emphasis added).

The Marketplace and the local departments are separate entities who determine Medicaid eligibility on differing bases, thus requiring a referral system for applicants who may meet other eligibility categories. The guidance provided in 14/2014 LCM-02 instructs local departments on how to process referrals from the Marketplace. Furthermore, for New York City recipients, it requires HRA, through EDITS, to extend uninterrupted coverage for five months until the case is renewed in WMS.

Therefore, it is not within the Appeals Unit's authority to extend Medicaid coverage for you through the Marketplace.

Decision

The June 6, 2015 notice of eligibility determination is AFFIRMED.

Your case is being referred to the Marketplace to make a determination on any possible referrals.

Effective Date of this Decision: November 13, 2015

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

It refers your case back to the Marketplace for a determination on possible referrals.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 after the date 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 U.S. Department of Health and Human Services. This must be done within 30 days of the date of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

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

The June 6, 2015 notice of eligibility determination is AFFIRMED.

Your case is being referred to the Marketplace to make a determination on any possible referrals.

This decision does not change your eligibility.

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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Legal Authority

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A Copy of this Decision Has Been Provided To:

[redacted]

[redacted]

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