TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Continuous Coverage for MAGI Individuals
ATTACHMENT:	LDSS-3868, "Notice of Medical Assistance Review"
EFFECTIVE DATE:	Immediately
CONTACT PERSON:	Local District Support Units Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services of the requirement to provide continuous coverage for individuals eligible for Medicaid under the Modified Adjusted Gross Income (MAGI) category.

Effective January 1, 2014, pursuant to authority found in Section 366(4)(c) of the Social Services Law and the Department's 1115 Waiver, continuous coverage was implemented for MAGI individuals. It was not anticipated that this policy change would impact MAGI-like cases on the Welfare Management System (WMS), because they would be transitioning to NY State of Health. However, due to the delay in transitioning MAGI-like individuals from WMS to NY State of Health, this is to advise districts that continuous coverage must be provided to MAGI-like individuals who are authorized coverage through the WMS system.

Similar to continuous coverage for children, adults who have been determined eligible for Medicaid under a MAGI or MAGI-like budget and who subsequently lose Medicaid eligibility, are eligible to have Medicaid coverage continue until the end of the 12-month authorization period. Certain exceptions apply. In the following situations, individuals are not entitled to receive continuous coverage:

- Unable to locate;
- Death;
- Consumer requests to have his/her Medicaid closed;
- Failure to provide or cooperate in obtaining a Social Security Number, if otherwise required;
- Failure to provide documentation of citizenship after the reasonable opportunity period;
- Moved out of State;
- Coverage established under MAGI in error;
- Undocumented pregnant women (only get 60 days post-partum);
- Failure to comply with absent parent (IV-D) requirements; and
- Individuals receiving treatment in a setting where Medicaid eligibility is not available.

Unlike the above examples of individuals that lose eligibility for Medicaid, incarcerated individuals remain eligible for Medicaid but are authorized with a different type of coverage. Districts must follow the suspension rules for incarcerated individuals as previously instructed.

In addition, effective January 1, 2016, individuals who turn age 65 and who no longer qualify under the MAGI category (e.g., are not a parent or caretaker relative), are not eligible for continuous coverage. Eligibility for such individuals must be determined under the SSI-related category of assistance.

Certain modifications are being made to WMS to support continuous coverage for MAGI-like individuals. Until system support is available, to the extent possible, local districts are advised not to store income changes that would render MAGI-like individuals ineligible for coverage under the MAGI category. Instead, income will be reported at renewal and if the individual is no longer eligible for Medicaid under MAGI at that time, appropriate action must be taken. When a change is reported and the household is re-budgeted (e.g. adding a case member or a change in income) and the change results in continued eligibility under MAGI-like budgeting, the change should be considered a renewal and an additional twelve months of coverage must be authorized. (See GIS 11 MA/012). If the reported change results in ineligibility, a written case note must be stored in the case file indicating that due to continuous coverage the coverage will continue unchanged until the end of the twelve month authorization period when the household will be given an opportunity to renew and the appropriate action will be taken at that time.

If it is brought to the district's attention that a MAGI-like consumer had Medicaid discontinued before the end of his/her 12-month authorization period, the individual's case must be reviewed and coverage restored if appropriate. Any Medicaid covered medical expenses paid by an individual as a result of not being authorized for continuous coverage must be reimbursed in accordance with the policies outlined in 10 OHIP/ADM-9, Reimbursement of Paid Medical Expenses Under 18 NYCRR §360-7.5(a).

The attached existing manual notice, "Notice of Medical Assistance Review, LDSS-3868" is to be used when changing an affected individual's eligibility and coverage. The "Agency reconsideration" box and the "We have determined eligibility as follows:" box must be checked. The following explanation should be included in the notice: "Your Medicaid coverage is being continued until [coverage end date] because certain individuals who have been determined eligible for Medicaid remain eligible for benefits for twelve continuous months from the date that they were last determined eligible. This decision is based on Section 366(4)(c) of the Social Services Law."

Districts are also advised that no recovery action may be taken with respect to a MAGI-like individual who would have remained eligible under continuous coverage had the district implemented the policy effective January 1, 2014.

Please direct any questions to your local district liaison.