TO:	Local District Commissioners, Medicaid Directors
FROM:	Gabrielle Armenia, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Continuation of Certain Policy Easements and Other Processes After Expiration of the Public Health Emergency Unwind Period
ATTACHMENT:	Attachment I – Desk Aid: SSI-R Chart
EFFECTIVE DATE:	Immediately
CONTACT PERSON:	Local District Support Unit Rest of State (ROS) (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to inform local departments of social services (LDSS) of updates to the policy easements provided in GIS 23 MA/14, "Updates to Medicaid Renewals and Other Processes in the Unwind Period". The State's Unwind period ended May 31, 2024. However, the Department of Health is continuing certain processes to support maintaining Medicaid coverage for eligible individuals. In addition, the Centers for Medicare and Medicaid Services (CMS) has extended various waivers it has approved under Section 1902(e)(14) of the Social Security Act ((e)(14) waiver) through June 30, 2025 to assist States with ongoing efforts to protect continuity of coverage for eligible individuals and comply with federal Medicaid renewal requirements. Therefore, the policy easements and processes described in this GIS will remain in effect through June 30, 2025.

MEDICAID RENEWALS – AUTOMATED RENEWAL PROCESS BASED ON SNAP

CMS's approval to continue this (e)(14) waiver provides authority to continue to renew Medicaid using the automated renewal process based on an individual's current receipt of Supplemental Nutrition Assistance Program (SNAP) benefits. Please refer to GIS 23 MA/14 for the full explanation of the automated renewal process based on SNAP, which applies to renewals for Aged, Blind and Disabled individuals in the SSI-related category, with some exceptions.

NOTE: An SSI-related Medicaid consumer with a Spenddown may be renewed based on a successful match via the SNAP Automated Process. Districts should still update income at client contact so that the consumer's income contribution can be accurately calculated. Spenddown recipients must continue to provide documentation of any third-party health insurance.

MEDICAID RENEWALS – WAIVER OF RESOURCE TEST

The authority to waive the resource test at renewal continues for SSI-related recipients renewing Medicaid eligibility. This waiver applies regardless of whether the recipient is renewing coverage for services provided in the community or for coverage of nursing home care. Since resources will not be reviewed at renewal, asset verification requests will not be sent to the Asset Verification System (AVS) for renewals.

Once an individual has been determined eligible for Medicaid, no action can be taken to discontinue coverage due to excess resources through June 30, 2025. Additionally, the resource

test continues to be waived through June 30, 2025 for Medicaid recipients in the following situations:

- *Change in Category –*
  - *Dually Eligible and/or over 65 with coverage through New York State of Heath Who Lose Eligibility Under Modified Adjusted Gross Income (MAGI) Rules:* Eligibility in NYSOH will continue to be maintained through a MAGI renewal;
  - *Dually Eligible and/or over 65 with coverage through the Welfare Management System (WMS) who change category and are subject to SSI-related rules*;
- *Request for Increase in Coverage From Community Coverage Without Long Term Care to Community Coverage with Long Term Care;*
- *Referrals from NY State of Health to WMS for Community Coverage with Long Term Care;*
- *Referrals from NY State of Health to WMS for Excess Income*

NOTE: The resource test is *not* waived for individuals newly applying for Medicaid and for Medicaid recipients requesting an increase in coverage to include nursing home care. Asset verification requests must be sent to AVS for these individuals. Once a consumer is determined resource eligible and Medicaid coverage is authorized, a subsequent increase in resources will not result in a discontinuance of coverage due to excess resources through June 30, 2025. There is no change to lookback requirements or transfer of assets rules.

Refer to Attachment I – Desk Aid: SSI-R Chart, which summarizes the Income and Resource Rules for SSI-related Renewals, New Applications, Requests for Increases in Coverage, and Referrals from NYSOH in effect in accordance with this GIS.

REFERRALS FROM NY STATE of HEALTH

NY State of Health enrolled Medicaid recipients in receipt of Medicare (dually eligible), turning age 65, or who are age 65 or older will continue to be maintained and renewed in NY State of Health through a MAGI renewal. Waiver of the SSI-related budgeting rules is a separate (e)(14) waiver from CMS. Waiver of the resource test for this population is described above in the Waiver of Resource Test section. Although these individuals will be categorically SSI-related, their eligibility will continue to be determined using MAGI rules until further notice.

LATE RENEWALS

Districts were reminded in GIS 23 MA/03 that individuals must be provided 30 days to respond to renewal notices, including those that are re-sent to a new address. If an individual's eligibility is discontinued in the renewal process for failure to recertify and the individual returns the completed renewal to the district prior to case expiration or within 90 days of the case closure for failure to recertify, districts may use the returned renewal to reopen the closed case and process the renewal. If eligible, coverage is authorized back to the effective date of discontinuance for the failure to renew. Renewals processed within this 90-day timeframe qualify for waiver of the resource test, as described above in Waiver of Resource Test section.

MEDICAID RENEWALS – RETURNED MAIL with OUT of STATE ADDRESS

If a Medicaid renewal is returned to the district with a yellow U.S. Postal Service sticker indicating the Medicaid recipient may have moved out of New York State (e.g. the yellow sticker shows an out-of-state address), the district must continue to attempt to contact the Medicaid recipient through at least two (2) different modalities such as: (i) a phone call to the recipient; (ii) checking WMS to see if the new out-of-state address is listed; (iii) contacting the recipient's Aged, Blind, Disabled Facilitated Enroller (ABD FE), if known, to check the address on file; or (iv) contacting

the recipient's Medicaid Managed Care Plan (Mainstream, Managed Long Term Care, etc.) to check the address on file. If the out-of-state address and move out of state is personally confirmed by the recipient or through one of the other modalities listed, the district must close the case with timely notice using the reason "Moved Out of State". If district's attempts to confirm the out-of-state address are not successful, the district must mail the renewal to the out-of-state address. If the Medicaid recipient contacts the district after receiving the renewal packet at the out-of-state address and confirms they have moved to another state, the district must close the case and issue timely notice using the reason "Moved Out of State". If the renewal packet mailed to the out-of-state address is not returned to the district by the requested due date and previous attempts to confirm the recipient's address using at least two (2) modalities are not successful, the district must close the case and issue timely notice for reason "Failure to Renew". The district must note all attempts to contact and all contact with the recipient in the case record.

IN-STATE ADDRESS/CONTACT INFORMATION UPDATES FROM PLANS

Districts are advised they may receive updated in-state contact information for a Medicaid consumer from the consumer's Mainstream, HARP, HIV-SNP, MLTC Plan, or NY Medicaid Choice, the Medicaid enrollment broker. Because Plans and NY Medicaid Choice are required to verify this new contact information, districts should continue to accept this information and update the enrollee's case record. Sending a confirmation notice to the consumer's address on file with the district is not required. This authority does not apply to out-of-state addresses received from a Plan or NY Medicaid Choice.

FAIR HEARINGS REQUESTED DURING AND AFTER THE UNWIND

For Medicaid fair hearings handled by the Office of Temporary and Disability Assistance's Office of Administrative Hearings (OTDA OAH) requested on or after April 1, 2023, appellants will continue to be granted Medicaid aid continuing automatically for discontinuances or reductions regardless of whether the appellant requests aid continuing or makes an aid continuing request more than 10 days from the notice date. Districts will receive aid continuing orders from OTDA OAH under regular processes. OTDA OAH will continue to inform Medicaid Managed Care Plans of aid continuing orders via encrypted emails. Any aid continuing granted in these fair hearings in the Unwind is not subject to recoupment, even if the agency's action is sustained by the fair hearing decision. Additionally, for fair hearings where aid continuing benefits are applicable, OTDA OAH may extend the 90-day time limit in which to take final administrative action.

Please direct any questions to your local district support liaison.