TO:	Local District Commissioners, Medicaid Directors
FROM:	Lisa Sbrana, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Updates to Medicaid Renewals and Other Processes in the Unwind Period
ATTACHMENT:	Attachment I - MA Extensions Based on SNAP Eligibility Attachment II – Rest of State SNAP Mitigation Period Process Flow Chart Attachment III – Desk Aid: SSI-related Unwind Chart
EFFECTIVE DATE:	Immediately
CONTACT PERSON:	Local District Support Unit Rest of State (ROS) (formerly Upstate) (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 provisions of GIS 23 MA/03 ("Unwind of Medicaid Continuous Coverage Requirement Related to the COVID-19 Public Health Emergency and Processing Cases Under Regular Rules") regarding Medicaid renewals and other processes that must be applied in the Unwind period. The provisions of GIS 23 MA/03 remain in effect subject to the updates provided in this GIS. The Unwind period refers to the period beginning April 1, 2023, through May 31, 2024. During this time, local districts will resume renewing Medicaid eligibility, beginning with cases with coverage authorization due to expire June 30, 2023 and ending with cases with May 31, 2024 "Authorization To" dates.

MEDICAID RENEWALS – AUTOMATED RENEWAL PROCESS BASED ON SNAP

The Centers for Medicare and Medicaid Services (CMS) has approved a waiver under Section 1902(e)(14) of the Social Security Act ((e)(14) waiver) to implement an automated renewal process during the Unwind based on an individual's current receipt of Supplemental Nutrition Assistance Program (SNAP) benefits. This will apply to renewals for Aged, Blind and Disabled individuals in the SSI-related category, with some exceptions noted below, and will be implemented in the Welfare Management System (WMS) beginning with cases with an "Authorization To" date of September 30, 2023 for cases outside of New York City referred to as Rest of State (ROS) and October 31, 2023 for Human Resources Administration (HRA) cases. This process will continue through the end of the Unwind period. Coverage will be renewed based on SNAP eligibility, however the resource and income amounts contained in the Medicaid Budget Logic (MBL) will not be updated with resource and income information from the SNAP budget. In addition, this SNAP automated renewal process does not apply to MAGI cases.

NOTE: Until this automated process can be implemented systemically in the WMS, ROS districts must perform a manual check to confirm whether a Medicaid consumer is on an active SNAP case, as outlined below in ROS SNAP Mitigation Period**.** The automated process for ROS will begin with cases with September 30, 2023 "Authorization To" dates. For HRA cases, there will be an interim systemic process as outlined below in HRA SNAP Mitigation Period. The automated process for HRA will begin with cases with October 31, 2023 "Authorization To" dates. Please

refer to SNAP Mitigation Process section later in this directive for additional information.

Cases that meet the following specific criteria from WMS will be selected for the SNAP automated renewal process: cases composed of an individual with an Individual Categorical Code (ICC) of Aged (10), Blind (11) or Disabled (12), a Budget Type of 04 (SSI-Related) and a SNAP Case Type of "31" or "32", a Food Stamp (SNAP) Payment Type of "96" (FS Ongoing Benefits), and a Food Stamp (SNAP) "Authorization To" date greater than the process run-date. Other Systems criteria will also be used to select cases for this process. Cases that will not be selected include:

- Medicare Savings Program-Only (MSP-Only);
- Medicaid Buy-in Program for Working People with Disabilities (MBI-WPD);
- nursing facility services cases with chronic care budgeting;
- consumers turning age 65 years old;
- Medicaid Cancer Treatment Program (MCTP);
- cases with unresolved immigration or citizenship;
- NY State of Health (NYSOH) referrals;
- Family Planning Benefit Program (FPBP) enrollees;
- Former foster care enrollees

To track cases that successfully go through the SNAP Automated Renewal process, a new Recertification Source Code "S" ("MA Extension Based on SNAP Eligibility"), will be systematically populated on WMS Screen 1 for ROS cases. HRA cases will be tracked by reason code "675" ("MA Extensions Based on SNAP Eligibility"). A CNS system-generated notice will be sent to consumers whose case is auto-renewed based on the SNAP process (see Attachment I – "MA Extensions Based on SNAP Eligibility". Reason Code 738 for ROS cases and Reason Code 675 for NYC cases).

Reports: The ROS SNAP Automated Renewal process will generate two (2) monthly reports for each district, which will be posted to Production Hosting Report & Enterprise Documents (PHRED). The WINR1774 ("MA Extensions Based on SNAP Eligibility – Eligible Report") lists all the cases that were successfully renewed based on SNAP and identifies which cases have unresolved Resource File Integration (RFI). Districts must check cases with an RFI alert and resolve the RFI following existing protocols, subject to any special direction provided in this GIS. The WINR1775 ("MA Extensions Based on SNAP Eligibility – Exception Report") lists the cases that were not renewed due to a pending Medicaid or SNAP transaction or clockdown closing. When a case listed on the WINR1775 report has a pending transaction alert (either a Medicaid or SNAP pending transaction alert), the district must manually review the case and resolve errors whenever possible. If the individual has an active SNAP case and there is no existing clockdown or pending transaction on either the SNAP or Medicaid case on the day of the district's check, the district must manually renew the Medicaid case based on receipt of SNAP benefits using the manual reason code C48 ("MA Extensions Based on SNAP Eligibility").

The HRA SNAP Automated Renewal process will generate three (3) monthly reports that will be posted to PHRED: CSVWINR0847-SNPEXT-RPT lists all the cases that were successfully renewed; PRMSNAPEXC lists all the cases that were excluded from the process; and CSVWINR0846-SNPERR-RPT lists all the cases that did not go through the process because of a pending transaction that has an error. HRA workers will review the case and resolve errors,

whenever possible, and extend the case for four (4) months so that the case can be re-run in a subsequent cycle through the SNAP Automated Renewal process.

Aged, Blind, Disabled Automated Renewal - Timing and Requirements Reminder: Once the SNAP Automated Renewal monthly process is run, cases that did not meet the SNAP Automated Renewal criteria may meet the criteria for the Aged, Blind and Disabled (ABD) Auto Renewal process. For ROS, this process resumed in April 2023 for cases with June 2023 authorization end dates. HRA's Disabled, Aged, Blind (DAB) Auto Renewal process resumed in April 2023 and included cases with authorization end dates through July 2023. (NOTE: this process is not running for MSP-only cases, and other system criteria such as unresolved verifications, open fair hearings, and cases with trusts could prevent a case from meeting the selection criteria for the ABD/DAB automated renewal processes.) Districts are reminded of the provisions of 11 OHIP/ADM-09 ("Automated Medicaid Renewal for Individuals with Fixed Incomes in Aged, Blind and Disabled Category") and that they receive reports of cases that fail the ABD automated renewal process and must follow Section IV. Required Action in 11 OHIP/ADM-09.

Any Medicaid renewal not selected by either the SNAP or ABD/DAB automated renewal processes will be subject to a manual renewal by the local district and will follow the existing renewal process, subject to special Unwind rules provided in this GIS, such as waiver of the resource test for renewals, or GIS 23 MA/03. Please refer to MEDICAID RENEWALS – WAIVER OF RESOURCE TEST section later in this GIS for additional information.

SNAP Mitigation Process

The SNAP Mitigation processes for ROS districts and HRA are outlined below. The processes match the case types outlined in the AUTOMATED RENEWAL PROCESS BASED ON SNAP, above: cases composed of an individual with an Individual Categorical Code (ICC) of Aged (10), Blind (11) or Disabled (12), a Budget Type of 04 (SSI-Related) and a SNAP case type of "31" or "32", a Food Stamp (SNAP) Payment type of "96" (FS Ongoing Benefits), and a Food Stamp (SNAP) "Authorization To" date greater than the date of the ROS district's manual check or HRA's systemic process run date (referred to as "SNAP Process case types"). Consistent with the Automated Renewal Process Based on SNAP, the SNAP Mitigation processes do not apply to the following cases: MSP-Only; MBI-WPD; nursing facility services cases with chronic care budgeting; consumers turning age 65 years old; MCTP; cases with unresolved immigration or citizenship; NYSOH referrals, FPBP enrollees and former foster care enrollees.

ROS SNAP Mitigation Period: Perform Manual SNAP Check Before Procedural Closing For Failure to Return Renewal Form or Requested Renewal Documentation

The ROS Mitigation Process applies to the SNAP Process case types, outlined above, that are due to renew with June 30, July 31, or August 31 "Authorization To" dates. When processing these Medicaid renewals, districts must perform a manual check for active SNAP eligibility in WMS when a renewal is received, and *before* a procedural closing of the case for:

- failure to renew (e.g., renewal is returned without a forwarding address; or there is no response to the renewal); or
- renewal received that requires additional information or documentation.

If the individual is on an active SNAP case with no SNAP clockdown or pending transaction

on the day of the district's check, the district must manually renew the Medicaid case based on receipt of SNAP benefits using the manual reason code C48 ("MA Extensions Based on SNAP Eligibility"); use of C48 by the district will trigger the applicable CNS renewal notice to the consumer. The resource and income amounts contained in the Medicaid MBL Budget should not be updated with information from the SNAP case. See Attachment II - ROS SNAP Mitigation Period Process Flow Chart.

HRA SNAP Mitigation Period: Systemic Process Before Procedural Closing
This HRA Mitigation process applies to the SNAP Process case types due to renew with June 30, July 31, August 31, and September 30, 2023 "Authorization To" dates. Any of these Medicaid renewals that are subject to procedural closing will be extended so that they can be included in the October, November, December 2023 or January 2024 renewal file, to be given the opportunity to be renewed based on the automated SNAP process criteria when that process begins in NYC WMS. Cases will be systematically extended for 4 months. This process will generate WINRO841, which is an error report listing all cases that did not go through this systematic extension process because of an error. HRA workers must review the case and resolve errors when possible, and manually extend the case for four (4) months so that the case can be re-run in a subsequent cycle. If a case is not renewed based on the SNAP automated process (or the subsequent DAB automated renewal process), the individual will be required to complete a manual Medicaid renewal.

MEDICAID RENEWALS – WAIVER OF RESOURCE TEST
To support the SNAP automated renewal process and other renewals for Aged, Blind and Disabled recipients renewing their Medicaid during the Unwind period, CMS has also approved an (e)(14) waiver of the resource test for SSI-related recipients renewing Medicaid eligibility in the Unwind period. 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 in the Unwind, asset verification requests will not be sent to the Asset Verification System (AVS) for renewals.

Since the resource test is waived for Medicaid recipients during the Unwind, no action is taken to discontinue Medicaid coverage if a recipient is determined to have resources above the applicable resource level prior to July 1, 2023, or on/after July 1, 2023. Once an individual has been determined eligible for Medicaid, no action can be taken to discontinue coverage due to excess resources. The resource test is also waived for Medicaid recipients during the Unwind period in the following situations:

- *Dually Eligible and/or over 65 on NYSOH Who Lose Eligibility Under MAGI Rules; Change in Category:* Application of the resource test is also waived during the Unwind for aged recipients or dually eligible recipients (those in receipt of Medicaid and Medicare) who lose eligibility under MAGI rules (due to age and/or receipt of Medicare benefits) and are categorically SSI-related, but whose eligibility in NYSOH is maintained through a MAGI renewal during the Unwind. Additionally, this waiver applies to all recipients who change category and are subject to SSI-related rules regardless of whether they are dually eligible or have coverage through NYSOH, or through WMS;
- *Request for Increase in Coverage From Community Coverage Without Long Term*

Care to Community Coverage With Long Term Care;
- *Referrals from NYSOH to WMS for Community Coverage with Long Term Care*
- *Referrals from NYSOH to WMS for Excess Income*

NOTE: The resource test is not waived for individuals *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. Applications for Medicaid include MSP-only or QI cases applying for full Medicaid coverage. 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 during the Unwind due to excess resources. There is no change to lookback requirements or transfer of assets rules – these rules continue to apply for individuals seeking Medicaid coverage of nursing home care.

Refer to Attachment III - Desk Aid: SSI-Related Unwind Chart, which summarizes the Income and Resource Rules in the Unwind for SSI-related Renewals, New Applications, Requests for Increase in Coverage, Referrals from NYSOH.

MEDICAID RENEWALS – EXCESS INCOME/SPENDDOWN

A Medicaid consumer with a Spenddown should be asked at next client contact or when completing a manual renewal to document income so that their income contribution can be accurately calculated. Instruction to Spenddown consumers to provide income documentation appears on the renewal form. However, if a recipient who is eligible to participate in the Excess Income program fails to document income on their manual renewal, the LDSS must determine eligibility based on the income the recipient has attested to, regardless of whether the recipient is SSI-related. Note that an SSI-related Medicaid consumer with a Spenddown may be renewed based on a successful match via the SNAP Automated Process or the manual ROS SNAP Mitigation 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.

Changes in monthly income during the Unwind must be processed as follows. If reported:
- *prior to full renewal*: budget only if it is a benefit to the consumer; accept attestation;
- *at full renewal*: regular rules apply; accept attestation if income documentation is not provided. Apply any changes to the income obligation prospectively;
- *after full renewal*: regular rules apply, even if the income obligation increases.

Districts should refer to Attachment III - Desk Aid: SSI-Related Unwind Chart, which summarizes the rules in effect during the Unwind for reported changes in income.

During the Unwind, districts must not terminate a Medicaid consumer's coverage based on the WINR 3180 report (MA Individuals – Provisionally Eligible – Over 3 Months) before the consumer has been given an opportunity to renew in the Unwind.

CHANGE IN CIRCUMSTANCE

When a consumer reports a change that will result in a discontinuance of coverage of nursing home care due to the imposition of a transfer of assets penalty, coverage may not be discontinued prior to July 1, 2023.

For example, nursing home coverage is authorized December 2022, based on the filing of a petition for guardianship. Upon appointment of the guardian in March 2023, the guardian attests to asset transfers that result in a penalty period of ten (10) months. The begin date of the penalty period must be the month the individual is otherwise eligible under the rules in place during the COVID-19 Public Health Emergency (PHE). Since the consumer is otherwise eligible in December 2022, the 10-month penalty period is December 2022 – September 2023. The nursing home coverage authorized during the PHE cannot be discontinued, so no action can be taken to discontinue nursing home coverage for the period December 2022 – June 30, 2023. The remaining 3 months of the penalty period (July 2023 – September 2023) may be imposed effective July 1, 2023, with the required 10-day notice.

NET AVAILABLE MONTHLY INCOME (NAMI) CHANGES AND NAMI RECONCILIATIONS
Since consumers must be provided an opportunity to complete a full renewal during the Unwind before an adverse action may be taken, including increasing an income obligation, the NAMI must not be recalculated based on a reported income change prior to renewal of nursing home coverage. Changes to a consumer's NAMI will be calculated and applied when coverage of nursing home care is renewed. Additionally, the income recalculation at the time nursing home coverage is being renewed must not include income changes for the six (6)-month reconciliation period.

Once coverage has been renewed, if a change in income or circumstance is reported subsequent to the renewal of coverage, the NAMI must be recalculated as appropriate. If applicable, the recalculation must include an adjustment for changes that occurred subsequent to the Unwind renewal and within the six (6)-month period prior to the month the NAMI is being recalculated.

MEDICARE SAVINGS PROGRAM (MSP)-ONLY - FAILURE TO RENEW
MSP-Only cases are not included in the SNAP Automated or SNAP Mitigation process. If an MSP-Only enrollee fails to renew, districts should extend the case for four (4) months so that the case can be run in a subsequent renewal cycle. This is a manual process requiring worker intervention. For cases that are manually extended, the worker must document the action in case comments to clearly indicate that the recipient was provided with a 4-month extension. An MSP-Only enrollee who fails to renew during the second renewal cycle should be closed for failure to renew, or closed for failure to submit required documentation if a response to a renewal generated a document request that was not complied with; the MSP-Only case should only be extended once. Districts must follow this special MSP-Only process for the duration of the Unwind.

For the one-time MSP-Only 4-month extension, districts must use the following:

ROS:
An undercare transaction with Y77 (no notice) reason code must be used to extend the authorization and coverage period for 4 months.

NYC:

- Cases with opening codes of H85 (QMB) will be systemically extended for 4 months; the same opening code will be used for the extension.
- Cases with opening code of H73 (QI) will be manually extended for 4 months. Upon review of the case, if the case is determined QMB eligible based on the

current budget in the case, the worker should change the opening code to H85 and extend the authorization for 4 months. If the case remains QI eligible, then the worker should manually extend the case for 4 months with opening code H73.

REFERRALS FROM NY STATE of HEALTH (NYSOH)

NYSOH-enrolled Medicaid recipients in receipt of Medicare (dually eligible), turning age 65, or who are age 65 or older will be maintained and renewed in NYSOH during the Unwind 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 section. During the Unwind, although these individuals will be categorically SSI-related, their eligibility will continue to be determined using MAGI rules.

The following referrals to districts will resume, beginning July 1, 2023. (See generally 13 OHIP/ADM-03):

- *Spenddown referrals*: individuals who have income above the MAGI level who indicate they have a disabling impairment or are chronically ill and elect to have their eligibility determined on a Non-MAGI basis;
- *Retroactive Medicaid coverage*: individuals applying on NYSOH who indicate they need help paying for medical bills incurred in the three (3)-month period prior to application. The district will determine if the individual is eligible for Medicaid under a Medically Needy category of assistance.

LATE RENEWAL

Districts were reminded in GIS 23 MA/03 that individuals must be provided 30 days to respond to renewal notices, including renewals that are resent to a new address. In the Unwind, 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 a case closed within the previous 90 days 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 will follow Unwind renewal rules including waiver of the resource test.

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 first 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; (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, 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 to the out-of-state address is not returned to the district by the requested due date and attempts to confirm the recipient's address using at least two (2) modalities are not successful, the LDSS 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.

MEDICAID RENEWALS - NY DOC SUBMIT

Medicaid recipients with a renewal date of June 30, 2023 or later whose Medicaid is administered in WMS and who reside in districts that participate in NYDocSubmit, will be able to upload their renewal form, in addition to any additional required documents, to NYDocSubmit when it's their time to renew. This will continue through the Unwind. Districts are required to check for the recipient's renewal form in the "Other" section of NYDocSubmit when accepting submitted documents for renewal. Uploaded renewal forms must display all completed pages, including the signature page. Information about submitting renewal forms via NYDocSubmit is available to Medicaid recipients through the Unwind Toolkit FAQs (found at https://www.health.ny.gov/stayconnected) and through the Department's media campaign videos and infographics provided to districts (found at https://info.nystateofhealth.ny.gov/PHE-tool-kit).

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 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. These new address update procedures are authorized pursuant to (e)(14) waivers from CMS and are effective for in-state address/contact information changes received on or after January 1, 2023 and will remain effective until May 31, 2024. This authority does not apply to out-of-state addresses received from a Plan or NY Medicaid Choice.

FAIR HEARINGS REQUESTED DURING THE UNWIND

During 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 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 – there is no change to these processes (and 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. These flexibilities have been authorized pursuant to a separate (e)(14) waiver from CMS for the Unwind.

Please direct any questions to your local district support liaison.