

WGIUPD

GENERAL INFORMATION SYSTEM
DIVISION: Office of Health Insurance Programs

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PAGE 1

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TO: Local District Commissioners, Medicaid Directors

FROM: Lisa Sbrana, Director
Division of Eligibility and Marketplace Integration

SUBJECT: Unwind of the Medicaid Continuous Coverage Requirement Related to the COVID-19 Public Health Emergency and Processing Cases Under Regular Rules

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
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The purpose of this General Information System (GIS) message is to inform local departments of social services (LDSS) that the Medicaid continuous coverage requirement (CCR) required by the Families First Coronavirus Response Act (FFCRA) and originally tied to the federal COVID-19 Public Health Emergency will end effective March 31, 2023, as required by the Consolidated Appropriations Act, 2023 (CAA, 2023). Guidance on the implementation of the continuous coverage provision can be found in GIS 20 MA/04 “Coronavirus (COVID-19) – Medicaid Eligibility Processes During Emergency Period.” The CAA, 2023 has revised rules around the Medicaid flexibilities that were put in place in 2020 and allows states to begin disenrolling ineligible consumers from Medicaid after a redetermination of eligibility. Pursuant to the CAA, 2023 the Centers for Medicare & Medicaid Services has issued guidance ([CMCS Information Bulletin from January 2, 2023](#) and [State Health Official Letter from January 27, 2023](#)) to states detailing requirements for readying Medicaid eligibility systems and processes for restarting Medicaid redeterminations, and returning to pre-pandemic regular Medicaid program rules and operations (the “Unwind”). This GIS message outlines how New York will implement returning to regular operations.

MEDICAID RENEWALS - Districts will resume responsibility for monthly renewals of Medicaid eligibility effective with July 1, 2023. In order to plan for a sustainable distribution of renewals in future years, approximately one twelfth (1/12) of the district’s caseload will be subject to renewal each month based on the consumer’s regularly scheduled renewal. Districts must complete their entire Medicaid renewal caseload by May 31, 2024 (June 1, 2024 “From” dates). The automated renewal process will be restored for the Unwind, with the exception of Medicare Savings Program cases. Selection of individuals for auto-renewal will follow pre-CCR selection criteria for individuals with fixed incomes in the Aged, Blind and Disabled category (See 11 OHIP/ADM-9). Single cases for Former Foster Youth will continue to be passively renewed.

Upstate cases with authorizations ending June 30, 2023 will be sent their renewal packet in the month of April 2023. Human Resource Administration (HRA) cases with authorizations ending

June 30, 2023 will be sent their renewal packet beginning in the month of March 2023. For Medicaid consumers with coverage on NY State of Health, cases with authorizations ending June 30, 2023 will be sent their renewal packet in the month of May 2023. Districts will begin processing their first renewals with "From" dates of July 1, 2023 prior to July 1, but an adverse action must not be effective prior to July 1, 2023. Outside of routine renewals, if a consumer reports a change prior to July 1, 2023, the continuous coverage rules as outlined in GIS 20 MA/04 apply.

Eligibility redeterminations with authorization and coverage "From" dates of July 1, 2023 and later are subject to regular Medicaid eligibility rules. This includes requesting documentation when eligibility criteria cannot be otherwise verified and from consumers renewing Medicaid coverage of nursing home care. Districts must ensure the Medicaid Budget Logic (MBL) and Welfare Management System (WMS) reflect eligibility based on current information received through the returned renewal packet. Resource File Integration (RFI) must be reviewed and resolved when processing the renewal.

Medicaid consumers must comply with conditions of eligibility at renewal, including pursuing available support and benefits. Referrals to comply with requirements, such as Veteran's benefits, absent parent and third party health insurance (TPHI) should be resumed at the individual's renewal starting with "From" dates of July 1, 2023. Note: Please refer to RESUMPTION OF MEDICARE/REQUIREMENTS and APPLICATION section later in this directive for additional information.

Consumers who the district determines are no longer eligible must have their coverage discontinued with timely notice. However, if the renewal packet is returned to the district as undeliverable mail, coverage must not be discontinued effective prior to the end of the current authorization period. Note: Please refer to RETURNED MAIL section later in this directive for additional information.

CASES MISSING VERIFICATION - Districts are not expected to resolve open verification requests before a consumer's scheduled renewal. Consumers with unresolved immigration or citizenship will be expected to document at their renewal. Extension of the reasonable opportunity period is allowable, if requested by the consumer and the consumer is making a good faith effort to obtain documentation; districts must assist consumers in obtaining such documentary evidence when requested. If documentation is not received, coverage must be discontinued with timely notice.

RESUMPTION OF MEDICARE REQUIREMENTS - Certain consumers' enrollment was maintained in Mainstream Medicaid Managed Care and Health and Recovery Plans during the CCR, including those newly in receipt of comprehensive Medicare. Apart from individuals enrolled in aligned Medicare Advantage Plans, disenrollment from managed care will be appropriate based on receipt of Medicare. The coverage code should be changed when the renewal is processed.

Individuals who became eligible for to apply for Medicare during the CCR will be required to comply with the Medicare application requirement. The Department will send letters to identified individuals to remind them of this requirement. The Upstate "Enroll in MCR" notice (informing individuals of the requirement to apply for Medicare) will resume starting June 10, 2023 and an individual's coverage may be ended beginning July 14, 2023, with 10 day notice, if the individual does not comply.

HIPP/MIPP Payments - Districts will be responsible for all previous Health Insurance Premium Payment program (HIPP) and Medicare Insurance Premium Payment program (MIPP) payment lines and will be expected to make the necessary updates should past payments need any adjustments. Any adjustments that result in a reduced payment must be made prospectively with proper notice. If it is determined that individuals received HIPP or MIPP overpayments during the CCR, the overpayments may not be recovered. HIPP determinations should be made at time of renewal using updated information. MIPP payments must be reviewed, and the appropriate eligibility determination made for the Medicare Buy-In or applicable MIPP Payment.

Districts should commence review of all reports previously reviewed regarding TPHI. This includes, but is not limited to, the Mobius TPHI BRMP5520 report to ensure correct enrollment in Medicaid Managed Care plans. The Medicare Buy-In deletion reports will remain with NYS DOH Bureau of Third-Party Liability.

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES - At renewal, districts must verify that a Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) individual is under the age of 65, working or in a current grace period, and has a current disability certification. Districts are reminded that the MBI-WPD individual must submit proof of work to remain in the MBI-WPD program but may attest to the amount of their income and resources at renewal. If the MBI-WPD individual is not working at the time of renewal, verification of the last day worked must be obtained from the individual. If the individual is not working at the time of renewal and has not been employed for six (6) months or more, the individual is no longer eligible for the MBI-WPD program and must have Medicaid eligibility determined under another category of assistance. This is because work activity is a requirement of program eligibility, and the maximum grace period allowance has been exhausted. MBI-WPD individuals who are in a current six (6) month grace period at the time of renewal can continue to be eligible for the MBI-WPD program for the remainder of the grace period if all other program requirements are met.

Districts must also verify at renewal that the correct MBI-WPD Individual Categorical Code (ICC) is used. If the individual has an ICC of 71 (Medicaid Buy-In - Medically Improved), districts must verify that the Disability Review Team Certificate (LDSS-639/DOH-5144) indicates that the individual has a Medical Improvement Group disability determination. If the disability certificate does not indicate that the individual has a determination of Medical Improvement, then ICC 70 (Medicaid Buy-In – Disabled Basic Group) must be used. If the individual is no longer MBI-WPD eligible or is age 65 or over, districts must determine whether the individual is eligible under another category of assistance and properly notice the individual of the determination. Districts must change the Individual Categorical Code (ICC) in the Welfare Management System (WMS) from “70” or “71” to the appropriate ICC code for any individual who is no longer eligible for the MBI-WPD program.

EXCESS INCOME CASES - For individuals participating in the Excess Income or Pay-in program, effective July 1, 2023, districts may no longer extend coverage for a six (6) month period based on a reason directly related to the COVID-19 Public Health Emergency (e.g., individual was quarantined, etc.), as was permitted pursuant to GIS 20 MA/04.

All Excess Income or Pay-in program cases must be processed under regular policy rules at the next regular renewal, with “From” dates of July 1, 2023, for existing cases, or upon receipt of any new application received on or after July 1, 2023, or when addressing a Medicaid consumer’s change in circumstance on or after July 1, 2023. Districts must continue to perform annual reconciliations. Districts are reminded of the provisions of GIS 22 MA/11 (“Increase of Medicaid Medically Needy Income Level to 138% of the Federal Poverty Level and Related Medically

Needy and MBI-WPD Resource Level Changes”): for current Medicaid consumers who do not contact the LDSS for a recalculation of their income in response to the December 2022 one-time letter, the LDSS should redetermine the individual’s income eligibility based on the new Medically Needy income level at the next consumer contact or at renewal, whichever comes first.

For Spenddown cases, districts must not seek retroactive recoupment of pay-in (Spenddown) payments not made during the CCR nor for Medicaid received during the CCR for coverage provided by the districts in accordance with GIS 20 MA/04.

SELF-ATTESTATION END - Attestation of income, resources and asset transfers during the look-back period allowed pursuant to GIS 20 MA/04 is no longer permitted after June 30, 2023. Additionally, effective July 1, 2023, individuals applying for coverage of nursing home care can no longer attest that the State has been named remainder beneficiary on an annuity. If proof that the State has been named remainder beneficiary is not provided, the annuity purchase is subject to treatment as an uncompensated transfer, pursuant to policy guidance provided in 06 OMM/ADM-5 (“Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility Changes”). If attestation that the State was named remainder beneficiary was accepted at application during the CCR, districts are reminded of the requirement for consumers to submit proof/documentation at renewal. Medicaid eligibility may be discontinued if a consumer fails to provide requested documentation at renewal.

GUARDIANSHIP - When an individual is alleged incapacitated and there is no one with legal authority to act on behalf of the alleged incapacitated person (AIP), assets are considered unavailable from the time a petition for guardianship is filed with the court, until the court appoints a guardian. Effective July 1, 2023, districts must no longer accept attestation of filing or of intent to file a petition for guardianship. Additionally, districts must review any cases from the CCR period where assets were considered unavailable based on an attestation from an attorney that proof of filing of the petition with the court would be provided once received to confirm proof of filing has been provided.

ASSET VERIFICATION SYSTEM - The Asset Verification System (AVS) process will resume for new applications and conversions effective July 1, 2023. For cases due to renew eligibility for coverage “From” dates of July 1, 2023 and onward, consumers will be systemically identified on the monthly renewal file (WINR 4133) and included in the batch file that is automatically sent to the AVS. The ad hoc function in the AVS portal must be used to submit requests for individuals who cannot be sent to the AVS via a batch file from WMS. Districts must resume requesting needed documentation to confirm information received from AVS. Policy guidance and requirements for use of AVS is provided in 17 OHIP/ADM-2 (“Asset Verification System”). Additionally, districts are not permitted to seek retroactive recoupment based on an AVS response for Medicaid received during the CCR for coverage authorized by the districts in accordance with GIS 20 MA/04.

RETURNED MAIL - During the return to normal operations, districts may receive returned mail from individuals who failed to report an address change during the CCR. If a renewal packet is returned with a yellow U.S. Postal Service sticker, indicating a new address, districts must update the address and send the renewal packet to the individual at the new address. Federal guidance requires that individuals are provided 30 days to respond to renewal notices, this includes renewals that are resent to a new address. Existing renewal timeframes allow for ample time for recipients to return their renewals before the case authorization end date.

If the returned renewal packet indicates that the individual has moved to an address in another county, districts should follow the provisions outlined in 08 OHIP/LCM-1 (“Continued Medicaid Eligibility for Recipients Who Change Residency (Luberto v. Daines)”).

Should a renewal packet be returned with no forwarding address, districts must check WMS for updated addresses in other programs, such as SNAP, HEAP, and TA. If there are no updated addresses available in WMS, districts must attempt to contact the individual utilizing any available information provided, such as phone number or email address, to obtain the most current address information. Only once a district has made a good faith effort through these additional steps but is still unable to obtain the current address of the individual, may the district take appropriate action to terminate Medicaid coverage with timely notice sent to the individual. Once regular renewals commence beginning with July 1, 2023 renewals, if the district receives returned mail and is unable to determine an individual’s current address and is unable to make contact with the individual, coverage must remain active until the end of the case authorization period. Districts must use the appropriate reason code for failure to renew, not whereabouts unknown. Districts must document all steps taken to locate an updated address for individuals with returned mail in the individual’s case file.

TRANSITION OF CASES TO AND FROM NY STATE OF HEALTH - The monthly referrals to WMS of most individuals turning age 65 with active Medicaid coverage on NY State of Health were suspended on March 19, 2020. This process is under review. The Department will provide further guidance in the near future. WMS will continue to receive referrals for such individuals who are also eligible for enrollment into a Managed Long Term Care plan.

“HX Facility” referrals to LDSSs of NY State of Health individuals who require long term care services and supports have continued during the CCR and will continue unchanged during the Unwind. Districts are to continue to authorize coverage on WMS using the appropriate transition reason codes and follow all other routine processes for these referrals.

The Department continues to plan the resumption of transitioning Modified Adjusted Gross Income (MAGI) cases from WMS to NY State of Health. A limited transition of some NYC consumers will continue. This population will include some cases discontinued from Temporary Assistance and individuals who should be enrolled in the Essential Plan due to their immigration status. These cases transitioned to NY State of Health during the CCR; however, consumers who fail to renew their coverage on NY State of Health will not be reopened in WMS, as was required during the CCR. Any further transition of MAGI cases from WMS to NY State of Health will not occur until further guidance is released.

APPLICATIONS - Flexibilities previously authorized by GIS 20 MA/04 due to the CCR will end effective June 30, 2023. Applications and requests for increases in coverage received on or after July 1, 2023 are to be processed in accordance with regular, pre-CCR rules and any related clarifications in this directive. Applications must be signed by the applicant or authorized representative. Documentation will be required when eligibility criteria, such as U.S. Citizenship, immigration status, income and resources cannot be verified. Districts are reminded of the existing flexibility provided for in 10 OHIP/ADM-4 (“Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants”), allowing the district the option of obtaining missing information from applications by calling the applicant to get information over the phone. The collection of information verbally must be noted in the case record and on the application. If the district is not able to reach the applicant by phone to collect needed missing information, the district must send a written request to the individual and authorized representative or person submitting the application on behalf of the applicant, for the missing information.

The following conditions of eligibility will be required for new applications and requests for increases in coverage received on or after July 1, 2023:

- Individuals turning 65 must apply for other benefits as a condition of eligibility, including, but not limited to Medicare, Social Security and Veteran's benefits.
- Districts must resume application of the requirement to pursue all available income and resources as a condition of Medicaid eligibility. This includes the requirement to pursue maximum periodic payments from a retirement account. If a consumer who is eligible to receive periodic payments without incurring a penalty does not show proof of filing for such payments, the consumer is ineligible for Medicaid; the retirement fund cannot be treated as a countable resource if a consumer fails to pursue periodic payments.
- Referrals to comply with absent parent requirements will resume effective July 1, 2023.
- Individuals with TPHI will again be required to provide information concerning available insurance and local districts are required to make new cost-effective determinations for possible reimbursement. Information provided regarding terminated or changed TPHI will require verification with the carrier, or written documentation to substantiate the termination or changes. Districts should request necessary information whenever they become aware of a possible change or during any renewal process.

Effective with cases with a Medicaid extension end date of June 30, 2023, districts will resume processing separate determinations for discontinuances or denials of Temporary Assistance, for consumers whose eligibility cannot be determined by the NY State of Health. Upstate counties must begin reviewing the WINR4133 report in April and May 2023, in order to identify separate determination cases with extensions ending before June 30, 2023. Identified cases should be extended 60 days to allow for a renewal packet to be generated. In New York City, downstate WMS staff will continue to extend separate determination cases with extensions up to May 31, 2023.

Districts are to resume use of the DOH-5147, "Submission of Application on Behalf of Applicant" (MAP-3044 for NYC consumers) as described in 17 OHIP/ADM-02. The Medicaid application must be signed by the applicant, the applicant's spouse on behalf of the applicant or an authorized representative. If an individual is unable to sign the Medicaid application, the individual signing the application must submit proof of their legal authority to sign on behalf of the applicant, or complete Section C (Reason for Submission/Section II of the MAP-3044) of the DOH-5147 and attest to the applicant's inability to sign the application due to incompetence or incapacity. Entering "COVID-19" in Section C is no longer a valid reason to accept the signature of another individual. Aged, Blind and Disabled (ABD) Facilitated Enrollers (FE) who are unable to assist individuals in person during the Unwind period may continue to utilize the DOH-5147 (or MAP-3044 form) when signed by the applicant authorizing the ABD FE to sign and submit the application on behalf of the individual. The DOH-5147 must be submitted with the application.

FAIR HEARINGS -

Currently pending fair hearings: Districts are advised that decisions on pending fair hearings requested before July 1, 2023 will be issued, and aid to continue on a currently pending fair hearing can be terminated as appropriate in accordance with a fair hearing decision issued on or

after July 1, 2023. Districts may not recoup for aid to continue benefits paid during the period of March 18, 2020 through June 30, 2023.

New fair hearing requests on LDSS or Plan actions taken on or after July 1, 2023 (“Unwind” requests / fair hearings):

Districts will be advised if there is any change in handling Unwind fair hearings, which are fair hearings requested on or after July 1, 2023 in relation to a district or Plan determination made on or after July 1, 2023. At the time of publication of this directive there is no change in how these will be handled but if that changes, districts will be informed.

There is no change to district obligations regarding fair hearings. The Office of Temporary and Disability Assistance’s Office of Administrative Hearings (OTDA OAH) is continuing its demonstration project conducting fair hearings to the greatest extent possible using telephone, video, and other means of communication, extending this project through March 12, 2023. (See OTDA GIS March 11, 2022 Transmittal 22-01). Districts should continue to stay informed of bulletins issued by OTDA OAH.

Please direct any questions regarding this GIS message to your local district support liaison.