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| **TO:** | Local District Commissioners, Medicaid Directors |
| **FROM:** | Gabrielle Armenia, Director<br>Division of Eligibility and Marketplace Integration |
| **SUBJECT:** | Expiration of Certain Post-Public Health Emergency Unwind Period Policy Easements and Other Process Updates |
| **ATTACHMENT:** | Attachment I – Updated Desk Aid: SSI-R Chart |
| **EFFECTIVE DATE:** | Immediately |
| **CONTACT PERSON:** | Local District Support Unit<br>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 24 MA/07, "Continuation of Certain Policy Easements and Other Processes After Expiration of the Public Health Emergency Unwind Period" and GIS 23 MA/14, "Updates to Medicaid Renewals and Other Processes in the Unwind Period." The State's Unwind period ended on May 31, 2024. Additionally, the Centers for Medicare and Medicaid Services (CMS) has not extended various waivers it has approved under Section 1902(e)(14) of the Social Security Act ((e)(14) waiver) beyond June 30, 2025. This GIS provides process updates and outlines the conclusion of various (e)(14) waivers ending June 30, 2025, with the exception of the (e)(14) waiver regarding Fair Hearings which is approved through December 31, 2025.

**MEDICAID RENEWALS – AUTOMATED RENEWAL PROCESS BASED ON SNAP**

In accordance with CMS's (e)(14) waiver approval requirements, the automated renewal process to renew Medicaid based on an individual's current receipt of Supplemental Nutrition Assistance Program (SNAP) benefits in effect through June 30,2025 has ended. This process applied to renewals for Aged, Blind and Disabled individuals in the SSI-related category, with some exceptions. The Welfare Management System (WMS) has been updated to end this process. The last batch of renewals subject to this process is as follows: for Rest of State (ROS), renewals with an "Authorization To" date of August 31, 2025; for Human Resources Administration (HRA), renewals with an "Authorization To" date of September 30, 2025.

**Please note, for HRA only,** cases selected through the SNAP automated renewal process before June 30th but have an "Authorization To" date after September 30, 2025 should be sent a renewal packet at the appropriate time to complete the renewal process.

**MEDICAID RENEWALS AND OTHER CHANGES – WAIVER OF RESOURCE TEST**

In accordance with CMS's (e)(14) waiver approval requirements, the waiver of the resource test at renewal in effect for SSI-related recipients through June 30,2025 has ended. This waiver applied to renewals for Aged, Blind and Disabled individuals in the SSI-related category and to reported changes to resources and certain requests for increases in coverage. Districts must apply the resource test for Renewals, Changes in Circumstances, Changes in Category, Requests for Increases in Coverage and Late Renewals received after June 30, 2025. Districts are reminded that coverage cannot be decreased

or terminated based on resource changes that occurred during the Unwind period and through June 30, 2025, when resources were waived. Please note, this does not apply to applications for coverage of nursing home care – there is no change to lookback requirements or transfer of assets rules. Assets must be reviewed at renewal, for changes and for coverage increase requests after June 30, 2025, and appropriate actions must be taken if the individual is determined to have excess resources.

The systemic Asset Verification System (AVS) process will resume beginning with the July renewal file (cases with September 30, 2025 end dates). For renewals received after June 30, 2025, districts must verify resources by submitting an AVS request ad hoc. Districts may also need to conduct ad hoc AVS requests, pursuant to 17 ADM-02, "Asset Verification System," for a non-applying spouse for cases authorized during the Public Health Emergency. Authorization to verify assets of a non-applying spouse is obtained if the non-applying spouse signed the Supplement A at application, or when a non-applying spouse signs the renewal form. For the Aged, Blind and Disabled Automated Renewal Process, the resource test has been systemically reinstated and will impact cases beginning with September 30, 2025, authorization end dates for ROS and October 31, 2025, authorization end dates for HRA.

The resource test must be applied after June 30, 2025, to SSI-related individuals in the following situations:

- Change in Category
- Dually Eligible and/or over age 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; and
- Referrals from NY State of Health to WMS for Excess Income.

Please refer to Attachment I for an updated SSI-R Chart, which reflects the end of the waiver of the resource test and the return to all regular rules effective July 1, 2025.

**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 who have lost or will lose eligibility under MAGI rules and who are not requesting long term services and supports, will be transitioned to Medicaid Eligibility Client Management System (MECM) for an SSI-related renewal, beginning in September 2025.

**LATE RENEWALS**

Districts were reminded in GIS 24 MA/07 and 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 renew 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 renew, districts must use the returned renewal to reopen the closed case by either reactivation if within 30 days or reregistering if beyond 30 days, and process the renewal. If determined eligible, coverage may be authorized back to the effective date of discontinuance for the failure to renew. As indicated above under Medicaid Renewals and Other Changes, a redetermination processed within this 90-day timeframe must have the resource test applied, in accordance with regular rules.

**MEDICAID RENEWALS - RETURNED MAIL; FAILURE TO RESPOND**

During the Unwind, districts were provided guidance in GIS 24 MA/07 and GIS 23 MA/03 regarding the district's responsibility for returned mail, including returned mail with out-of-state addresses. The following is updated guidance regarding returned mail, and guidance regarding failure to respond to renewal:

Returned mail – no forwarding address

For returned mail with no forwarding address, districts are encouraged to conduct multiple modalities to reach a recipient. Districts will no longer be required to make two (2) different attempts to contact the recipient through phone, email address, an Aged, Blind, Disabled Facilitated Enroller (ABD FE) or the recipient's Medicaid Managed Care Plan; however, districts are required to check WMS for an updated address or contact information. In circumstances where there is a more current address available in WMS from another program area, such as SNAP, HEAP, and TA, districts must update the contact information on the Medicaid case and resend the returned mail or renewal to the recipient's updated address. If the recipient does not return their renewal, the district may close the case for failure to renew. If the district receives a returned renewal and is unable to determine an individual's current address, coverage must remain active until the end of the case authorization period.

Returned mail – forwarding address

Districts may also continue to receive returned mail or renewals from Medicaid recipients who have moved within the district, to another county or out of state. For recipients whose renewal is returned with a U.S. Postal Service (USPS) sticker indicating the recipient 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)." For recipients whose renewal is returned with a USPS sticker indicating the recipient has moved to another state, districts must check WMS to see if the new out-of-state address is listed in another program area, such as SNAP, HEAP, and TA. If WMS indicates there is a new confirmed out-of-state address, districts should update the address on the Medicaid case and send a closing notice to the address indicating closed for reason code "moved out of state." If there is no updated address available in WMS, districts should mail the renewal to the address listed on the USPS sticker. If the consumer contacts the district indicating they have moved out of state, the district may close the case for reason code "moved out of state." If the district does not receive the renewal back by the last day of the current eligibility period, the district may close the case for "failure to renew."

Failure to respond to renewal

If the district does not receive a Medicaid renewal by the renewal due date, the district will only be required to check WMS for another program area, such as SNAP, HEAP, and TA, update the address if applicable, and resend the renewal to the most current address. If WMS does not have a more recent address, districts should close the case on the last day of the authorization date for "failure to renew," with timely notice. While districts are encouraged to conduct multiple modalities to attempt to reach a Medicaid recipient for purposes of renewal, districts are not required to conduct two (2) modalities of communication outreach to the consumer for a renewal.

**FAIR HEARINGS REQUESTED 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. CMS has extended this (e)(14) waiver through December 31, 2025.

Please direct any questions to your local district support liaison.