

**TO:** Local District Commissioners, Medicaid Directors

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

**SUBJECT:** Coronavirus (COVID-19) – Medicaid Eligibility Processes During  
Emergency Period

**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) of several changes to support Medicaid eligibility and enrollment during the Coronavirus (COVID-19) outbreak. These changes are effective immediately and shall remain in effect for the duration of the COVID-19 public health emergency.

In conjunction with the recent federal “Families First Coronavirus Response Act” (FFCRA) and existing federal Medicaid regulations that provide states with certain flexibilities during times of a disaster, the following changes are to ensure that no one who was in receipt of Medicaid coverage on or after March 18, 2020, loses their Medicaid coverage during this public health emergency, unless an individual voluntarily terminates coverage or is no longer a resident of the State. Additional flexibilities are being authorized to ensure that individuals can access Medicaid benefits and that local social services districts can process applications during this health crisis.

**RECERTIFICATIONS** - Medicaid cases are being extended and individuals will not be required to renew their Medicaid eligibility during the emergency period. All active Medicaid cases with authorization and coverage dates ending in March, April, May and June will be systemically extended for 12 months.

- For upstate local districts, cases will have a unique authorization number and Transaction Office/Unit/Worker of “DOH COVID EXTEN”. MBL budget dates will also be updated if the existing budget effective dates match the existing authorization period. The same Office/Unit/Worker will be used on the budgets. A special Client Notice System (CNS) notice will be sent to individuals when their coverage is extended. The notice will inform the individuals that they will not lose their Medicaid coverage during the pandemic emergency.

**Note:** Cases that cannot be extended through the systemic process will be identified and extended manually by the Department of Health. This includes cases in “clock down” status, cases where the coverage “To” date does not match the authorization “To” date and any case that closed on or after March 18, 2020 but did not have coverage to the end of March 2020. Excess Resource cases “clocking down” will be extended for six (6) months.

The upstate "Enroll in MCR" notice (informing individuals to apply for Medicare) will be suppressed and the closing process will be suspended. In addition, the Asset Verification System (AVS) process will be suspended.

- In New York City, all active cases will also be extended. No Medicaid case will be closed for failure to renew or failure to provide documentation. Any case that is closed for failure to renew or failure to provide documentation that had Medicaid coverage on or after March 18, 2020 will be re-opened and coverage restored to ensure no gap in coverage. Renewals will be extended for 12 months.
- The Department's Office of Health Insurance Programs, Third Party Health Insurance Unit, will extend MIPP and HIPP payment lines for extended cases. Districts must extend BICS payment lines.
- Former SSI cash cases and any discontinued Temporary Assistance/Medicaid cases that require a separate Medicaid eligibility determination will have Medicaid coverage extended. No renewal is required to be sent at this time and no redeterminations are required at this time.
- Recertifications that are returned to the district are not required to be processed. If a district does process a recertification or reported change, it is important to note that Medicaid coverage as it existed on or after March 18, 2020 must be maintained and cannot be decreased or discontinued throughout the duration of this emergency. This includes maintaining coverage for an individual who may otherwise age out of a Medicaid eligibility group (e.g., turning age 65). If an individual informs the district of a change that results in an increase in Medicaid coverage, the district is required to process the change. During this emergency, local districts should not increase an individual's spenddown liability as that is a reduction in coverage.
- Individuals in the Medicaid Buy-In Program for Working People with Disabilities who have experienced job loss as a result of the COVID-19 emergency must be given a grace period due to loss of work. If applicable, the grace period should be extended for six (6) additional months.
- Individuals who move to another county should continue to be transitioned to the new county using the *Luberto* process.
- Individuals participating in the Excess-Income or Pay-In program who met their spenddown in March will have coverage extended for six (6) months. Individuals who have a spenddown and have been unable to submit a bill or payment due to the COVID-19 emergency should contact their local district. When contacted, districts should authorize coverage for such individuals for six (6) months and maintain a list of these cases.

- If a renewal, notice or other correspondence is returned to a district with no forwarding information, the district must maintain coverage for the case for the duration of this emergency. Medicaid should not be discontinued due to whereabouts unknown.

### **TRANSITION OF CASES TO AND FROM NY STATE OF HEALTH (NYSOH)**

- Effective April 2020, upstate transitions from WMS to NYSOH will be suspended. Any case transitioned with WMS coverage ending in March, where the individual did not gain Medicaid coverage through NYSOH, will have Medicaid coverage re-opened on WMS and extended. The Department of Health will be responsible for the transactions to restore coverage, if applicable.
- For NYC transition cases from WMS to NYSOH, any individual transitioned to NYSOH who does not gain Medicaid coverage through NYSOH will be re-opened with coverage on WMS. Downstate WMS staff will restore coverage, if applicable.
- The monthly referrals to WMS of individuals turning age 65 with active Medicaid coverage on NYSOH were suspended on March 19, 2020. However, referrals for those turning age 65 may be sent to districts on a daily referral basis due to different NYSOH trigger identifiers. This should be a much smaller volume of individuals for districts to process. Other referrals from NYSOH to WMS will continue at this time, including "HX Facility" referrals for individuals who require long term care services and supports. Districts are to continue to authorize coverage on WMS using the appropriate transition reason code. Cases with an authorization and coverage end date in March, April, May or June will be extended. Coverage must be maintained throughout the emergency period.

### **MEDICAID APPLICATIONS**

- **Self-attestation** - Districts must allow self-attestation for all eligibility criteria, except for immigration/identity status (see below for citizenship and immigration status). This includes when processing an initial application, a request for increased coverage and redeterminations.
  - **Citizenship and Immigration Status** - If citizenship is not verified through the data match with the Social Security Administration or immigration/identity status documentation is necessary to complete a determination of eligibility, coverage should be authorized, if the individual is otherwise eligible. The individual should be granted a 90-day reasonable opportunity period to provide such documents; if this emergency period has not ended and supporting documents have not been received at the end of the reasonable opportunity period, coverage should be extended for a second 90-day period.

Districts should continue to follow procedures outlined in 10 OHIP/ADM-8 to give a reasonable opportunity period to consumers who are attesting to be U.S. Citizens. For

consumers who are not able to provide documentation of their immigration status when their application is submitted, the reasonable opportunity status should be authorized in the following manner.

Upstate:

- Use opening reason code H2W with notice indicator “N” so a notice is not produced systematically. A manual notice will need to be sent;
- Authorization and coverage period will be current month plus four (4) months;
- Worker must enter RVI code 6 (Transfer from NYSOH);
- ACI code must be Z; and
- State/Federal Charge code must be 67.

Cases opened with reason code H2W will be put into a renewal period after approximately one month. However, the cases will be extended during the emergency period, as described above.

New York City:

- Use opening reason code D20 (NYC will be notified when this code is in production);
  - Authorization and coverage will be 12 months. However, cases will be put in a renewal cycle earlier, as necessary, after the emergency in order to obtain documentation; and
  - ACI code will be left blank.
- Nursing home cases - Individuals applying for Medicaid coverage of nursing home care can attest to income and resources during this emergency. This includes attesting to any transfer of assets in the look-back period. The Access NY Supplement A (DOH-5178A) must be completed. Districts may also accept attestation that an applicant has named the State as beneficiary of any remainder interest in an annuity in order to determine eligibility; however, proof / document submission of this will be required at renewal.
  - **Application Signatures** – During this period, for individuals in hospitals or nursing homes, the Access NY application (DOH-4220-1) and/or Supplement A (DOH-5178A) can be signed by someone acting on the individual’s behalf. If a signature on the application cannot be obtained from the applicant/recipient (A/R) or the A/R’s spouse, Attachment I to 17 ADM-02, “Submission of Application on Behalf of Applicant” DOH-5147 (MAP-3044 for NYC A/Rs), must be signed by the person signing and submitting the application and must accompany the application. In Section C of the DOH-5147 (Reason for Submission/Section II of the MAP-3044) “COVID-19” should be noted if the A/R cannot sign the form due to access issues. All information must be completed on the application. If a signature can be obtained from the applicant/recipient, Section D (Authorization to Apply for Medicaid on Applicant’s Behalf) of the DOH-5147 form should be signed by the A/R authorizing another person or the facility to apply on behalf of the individual.

Aged, Blind and Disabled (ABD) Facilitated Enrollers (FE) who are unable to assist individuals in person during this time will be following a similar process with one exception: the DOH-5147 form (or MAP-3044 form) will be 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.

- **Information Needed to Process the Application** - During this period, if an application or Supplement A is missing required information, the district should contact the applicant, authorized representative or the person submitting the application on behalf of the applicant, if applicable, by email or telephone to obtain the necessary information. The district does not need to receive the information in writing and can accept information verbally. The eligibility staff should note in the case record any information obtained by phone and make a notation in the case record that information was received verbally due to COVID-19 circumstances.

If after three (3) attempts, the local district is unable to contact the individual, the individual's authorized representative or the person who submitted the application on behalf of the applicant (including when no response is received from an email contact), the local district must send a written request to the individual and the authorized representative or person submitting the application on behalf of the applicant, for the missing information. The request sent must include a response due date of no less than 10 days. Information concerning how the missing information can be given to the district by telephone and/or email must be included in the letter sent requesting the information.

- **Conditions of Eligibility** - With the closure of businesses and reduced government workforces during this period, the following conditions of eligibility are being waived.
  - Individuals turning age 65 must not be required to apply for other benefits as a condition of eligibility, including but not limited to Medicare and Social Security benefits.
  - Referrals for Veterans Benefits are suspended.
  - Applicants with an absent parent must not be referred to child support and will not be required to comply with child support requirements as a condition of Medicaid eligibility.
  - Individuals with available Third Party Health Insurance will not be required to provide information concerning available insurance and local districts are not required to make new cost effective determinations for possible reimbursement if sufficient information is not available. If an individual provides information about insurance coverage that has terminated, the district should end the coverage or forward the information to [TPL@health.ny.gov](mailto:TPL@health.ny.gov) and the TPHI unit will take the appropriate action.
  - For retirement accounts and annuities, districts may accept attestation of the amount currently received.
- **Pending Reports** - Due to the limited ability of many consumers to provide documentation in response to a request at this time, no documentation should be requested based on reports received after March 1, 2020 of failed verification of Social Security numbers or in response

to a Resource File Integration (RFI) "hit" or Asset Verification System response.

- **Fair Hearings** - During the period of this emergency, consumers in Aid to Continue status on or after March 18, 2020 must be maintained with the same coverage. Medicaid coverage cannot be decreased or discontinued.

There is no change to district obligations with regard to fair hearings. For any changes in the hearing process during this period, districts should stay informed of bulletins issued by the Office of Temporary and Disability Assistance's Office of Administrative Hearings, including but not limited to OTDA GIS Transmittal 20 TA/DC014.

Please direct any questions to your local district support liaison.