

**TO:** Local District Commissioners, Medicaid Directors, Temporary Assistance Directors, Legal Staff, Fair Hearing Staff, Staff Development Coordinators

**FROM:** Judith Arnold, Director  
Division of Coverage and Enrollment

**SUBJECT:** Allowing Reported Changes to Be Treated as a Renewal for Medicaid and Family Health Plus

**EFFECTIVE DATE:** June 1, 2011

**CONTACT PERSON:** Local District Support Unit:  
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The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) that the State Department of Health (SDOH) is rescinding a policy included in 08 ADM-04, "Renewal Simplification for Medicaid and Family Health Plus Recipients", that prohibited districts from changing an authorization period when a recipient reported a change in circumstances before the next annual renewal date. This GIS message provides instructions on treating a recipient's reported change in circumstances as a renewal.

In 08 ADM-04, districts were instructed not to treat a reported change in a recipient's circumstances as a renewal, in an effort to establish a consistent renewal date and increase retention. Since 2008, additional renewal simplification rules have been extended to community Medicaid recipients. Most Medicaid recipients and all Family Health Plus (FHPlus) recipients can attest to income, resources (if applicable) and residence at renewal. The elimination of a resource test for FHPlus and non-SSI-Related Medicaid A/Rs has simplified the process of re-determining eligibility based on a reported change. To reduce the need to re-determine Medicaid or FHPlus eligibility more than once in a 12-month period, the Department is reinstating its previous policy to allow LDSS to consider a recipient's reported change in circumstances as a renewal. Districts may extend the authorization of the individual or family, if determined Medicaid or FHPlus eligible, for 12 months from the date of the re-determination.

The Department is adopting the policy outlined in 03 ADM-02, "Mail-in Renewal (Recertification) Process for Medicaid/Family Health Plus/Child Health Plus A", that allows districts to treat an eligibility determination completed as a result of an individual or family reporting a change in circumstances as a renewal for persons other than those receiving chronic care. Previously, districts were instructed in 08 OHIP/ADM-4, that if a change was reported by telephone, before the case could be rebudgeted, a signed, written statement had to be submitted by the client. Effective with the release of this GIS, a recipient's attestation of a change in circumstances by telephone is sufficient to rebudget the case, and a written statement is no longer required. When requesting to add an individual to the case, current

documentation requirements still apply. It is important to note that when a recipient reports a change that does not require a new budget, such as an address change, and the LDSS wants to consider this a renewal, the worker must confirm that no other changes in the household have occurred, such as an income change that would require a new budget. The worker can authorize the case for an additional 12 months using an 06 Transaction Type (Recertification/ Reauthorization). It is necessary to use the 06 Transaction Type whenever possible, to ensure a new Continuous Save Date (CSD) is set for any children under age 19 on the case.

If an individual whose renewal is being handled by New York Health Options/ the Enrollment Center reports a change within the three months prior to the end of the authorization, the LDSS should make the reported change and if treating it as a renewal, contact New York Health Options by fax using the designated LDSS fax coversheet to request that the renewal be withdrawn from HEART. New York Health Options will continue to follow-up with the household for failure to respond to the renewal unless the case is withdrawn from HEART. The fax coversheet will be provided to LDSS with the Enrollment Center protocols.

In counties that have combined Food Stamp (FS) and Medicaid units, renewals received for FS may also be used to renew the Medicaid case and authorize 12 months of Medicaid coverage if re-determined eligible.