K-0000 RENEWALS

K-100 REQUIREMENTS

Federal regulations require that the agency periodically review the eligibility of Medicaid beneficiaries.

Renewal is the process of verifying that the beneficiary continues to meet all eligibility factors of a particular program for ongoing eligibility in that program. Prior to making a determination of ineligibility, the agency must consider eligibility under all other Medicaid programs.

Beneficiaries shall not be asked to provide verification of information that:

- Is not needed to determine ongoing eligibility;
- Has already been provided or contained in record; and/or
- Is verifiable through electronic data or other source, including information received from the Marketplace.

The agency must promptly determine eligibility between regular renewals whenever there is information received about a change in a beneficiary's circumstances that may affect eligibility, unless otherwise noted. Refer to L-500, Action on Changes.

At renewal, apply policy in effect at the time of the renewal, unless specifically stated elsewhere in this manual.

Types of renewals

LaMEDS determines the type of renewal used to review ongoing eligibility.

- Streamline *(Ex parte)* renewal –a process used to verify eligibility criteria based on the information in the beneficiary's Medicaid file and accessed through electronic data matches without the active involvement of the beneficiary.
- Standard Renewal – a prepopulated renewal form sent to the beneficiary(ies) and used as a data collection instrument to secure update information when coverage cannot be reestablished through the ex parte renewal process.

- Express Lane Eligibility (ELE) – automatic recertification of certain children in an active Supplemental Nutrition Assistance Program (SNAP) case

Periodic Renewal of Eligibility

The agency must renew eligibility; if able to do so, based on reliable information obtained from electronic data sources. The streamline renewal process begins 60 days prior to the renewal date.

If a streamline renewal is not possible, the agency sends a pre-populated renewal form to the beneficiary. The renewal form includes information from the agency record such as contact information, household members, tax filing status, and resources as well as information retrieved from data sources such as earned and unearned income.

The beneficiary must sign and return the form and provide any necessary information. The beneficiary may return the signed form through any modes available for submitting applications including postal mail, electronic mail, fax, in-person, and thru the self-service portal. Allow the beneficiary at least 30 days from the date of the renewal form to respond and provide any necessary information.

Note:
If the beneficiary fails to return the renewal form or requested information, refer to G-0000 before terminating eligibility.

If the agency receives a signed renewal form and any verification after the due date, but prior to the end of the renewal period, eligibility must continue until the information received is reviewed and a final determination is made.

Beneficiaries who are no longer eligible in their current program must be reviewed for potential eligibility in other programs.

If additional information is needed to make the determination, send a request for information and allow the beneficiary 30 days to respond. If the agency is not able to complete a determination for the other program before the end of the renewal period, coverage must continue until a final determination is made.

Example:

John is enrolled in MAGI and his renewal date is June 30, 2021. The agency starts the renewal process April 1, 2021. The agency has information that indicates John may no longer be eligible on MAGI basis but the information indicates he may be eligible on non-MAGI basis. Request for additional information sent May 7, 2021. Information is received June 30, 2021. The agency must continue to provide coverage after the renewal date while the information is processed.

MAGI Beneficiaries

Medicaid beneficiaries whose financial eligibility is determined using Modified Adjusted Gross Income (MAGI) income rules must be renewed every twelve (12) months and not more frequently unless there is a change in circumstances that may affect eligibility.

Non-MAGI Beneficiaries

Medicaid beneficiaries whose eligibility is not based on MAGI rules must be renewed every twelve (12) months unless there is a change in circumstances that may affect eligibility.

Notice of Decision

A notice of decision must be sent notifying the beneficiary of any decision affecting their eligibility.

Beneficiaries who fail to return the renewal form or requested information must be provided an advance notice for termination of coverage.

Beneficiaries whose coverage is reduced from a full benefit program to a limited benefit program or who are determined ineligible for Medicaid or CHIP coverage must be provided advance notice for termination of coverage.

Reconsideration Period for Failure to Provide

The agency must reconsider the beneficiary's eligibility without requiring a new application if the renewal form and/or requested information is returned within 90 days after the date coverage is terminated. The renewal form returned within the reconsideration

period serves as an application. The agency will determine eligibility consistent with timeliness standards used for applications.

Effective date of coverage for Medicaid is the first day of the month the renewal form is returned. Up to three months retroactive coverage is available if Medicaid services were received following the termination of benefits and the individual meets the Medicaid eligibility requirements.

Exceptions:
Do not consider retroactive coverage for any program that does not allow retroactive coverage at application.

Special Considerations for Pregnant Women

The agency must provide coverage through the last day of the month in which the 12 months continuous eligibility for extended post-partum period ends.

Exception:
Phase IV pregnant women are not entitled to the 12 months continuous eligibility for extended post-partum. **

Advance Notice

Advance Notice is used to:

- Inform a beneficiary (or the person authorized to act on their behalf) of a planned adverse action date to terminate, suspend, or reduce benefits;
- Explain the reason for the action;
- Inform the beneficiary of their appeal rights.

Exceptions for Advance Notice

The agency may mail a notice no later than the date of action if:

- The beneficiary or authorized representative provides a written statement that they no longer wish to receive services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.

- The beneficiary's whereabouts are unknown and the renewal form is returned with no forwarding address.

- The death of the beneficiary is verified and there are no other Assistance Unit (AU) Members.

- The agency has confirmed the beneficiary has Medicaid in another state or territory.

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