COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

TITLE:	**RENEWAL GUIDANCE FOR MEDICAL ASSISTANCE PROGRAMS**
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Purpose and Audience:

The purpose of this Operational Memo is to provide all Eligibility Sites, (county departments of human/social service and Medical Assistance (MA) Sites, and Eligibility Application Partners (EAP)) with information about regulations 42 C.F.R. §435.916 and §457.343 on completing redeterminations of eligibility for Medical Assistance and Child Health Plan *Plus* (CHP+) members. This guidance is intended for all Eligibility Workers and Supervisors. Please share this memo with anyone who works with Health First Colorado/CHP+ applicants and members.

Information:

Federal regulation requires state Medical Assistance programs to renew eligibility once every 12 months (42 C.F.R. §435.916(a)(1)). A redetermination or renewal period is up to one year of coverage and starts from the initial application approval month. States must first attempt to conduct an "Medical Assistance (MA) Ex Parte" renewal for all household members. An MA Ex Parte renewal is a redetermination of eligibility based on reliable information available to the agency without requiring additional information from the member. Reliable information may include information available in the member's case and other more current information available such as available data

sources, paper documentation or other high-level programs in CBMS to include Adult Financial (AF), Colorado Works (CW), and Supplemental Nutrition Assistance Program (SNAP).

Information from the initial determination at application or the member's last renewal is not considered recent or reliable, unless it relates to a circumstance generally not subject to change, such as citizenship.

Medical Assistance Ex-Parte process:

As part of the MA Ex Parte process the agency must attempt to renew a member's eligibility for Medical Assistance based on available information, using information in the member's case file, as well as electronic data sources, and information previously received from the high-level program groups used in CBMS for MA Ex Parte to include: Adult Financial, Colorado Works, and Supplemental Nutrition Assistance Program (SNAP).The MA Ex Parte process consists of the Colorado Benefits Management System (CBMS) identifying all renewals that will be due and calling interfaces, checking for outstanding verifications, and performing a reasonable compatibility check. This process will determine whether a Medical Assistance renewal will be approved or if a renewal packet will be sent to the household.

If the agency can renew eligibility based on the available information, the agency will provide an approval Notice of Action (NOA), instead of sending a renewal packet. The member is not required to sign and return the approval notice or notify the agency if all information in the notice is accurate. Members will have the opportunity to review the information used to make their eligibility determination and make any updates via PEAK or with their local eligibility site. The member is obligated to inform the agency if any of the information contained in the notice is inaccurate or subsequently changes within 10 business days. Per the Rights and Responsibilities within the Medical Assistance application, a member who is found to be eligible for benefits must report changes that could affect their eligibility within 10 days after the change happens. If a member fails to report changes within 10 days, a member's eligibility will not be impacted for that reason. A change reported by a member may impact their eligibility determination and failure to report a change may result in the member receiving the wrong Medical Assistance benefit. Examples of changes to report include income, address, marital status, family size, or resource changes.

If a member is eligible for the Child Health Plan Plus (CHP+) program and an enrollment fee is required, the member will not be approved for coverage until the enrollment fee is paid. The enrollment fee will be due early prior to the actual coverage begin date. For the Working Adults with Disability Buy-In(WAwD) or Children with Disabilities Buy-in (CBWD) the member will be approved and will be notified of the

premiums that are due. The member will receive an enrollment fee/premium notice and will be paying for coverage that begins in the future. If the member fails to pay the enrollment fee/premium their coverage will end at the end of their renewal certification period.

If sufficient information is not available to complete a redetermination through the MA Ex Parte process, or if the state has information that indicates a member may be ineligible, the agency must provide the member with a renewal form and inform the individual of any additional information or documentation needed to determine eligibility. A renewal packet will be prepopulated and sent to the household with the most recent, reliable and relevant information. A member will have at least 30 calendar days (42 C.F.R. §435.916(a)(3)(i)(B)), from the date of the prepopulated renewal form to return the form and provide any additional information requested by the agency. The renewal packet will now include a signature form and is required to be signed and returned regardless if there are or are not any changes to report. When an eligibility worker is processing a renewal packet or a returned verification check list, it is expected for the eligibility worker to complete the appropriate data entry fields and mark the data entry complete to "Yes."

Verification Policy:

When performing the MA Ex Parte review at redetermination, "Client Statement" will not be an acceptable source for existing earned income records and verification will be requested if this information cannot be verified through an income interface. Self-attestation of income will be verified through Equifax via the Federal Data Services (FDSH) and/or the Work Number (TWN), and the Income Eligibility Verification System (IEVS). Paper documentation will only be required if self-attested income cannot be verified through an electronic data source or does not meet the reasonable compatibility check and the attestation does not meet the standard for a reasonable explanation. If required verification items cannot be verified through an interface or if recent documentation has not been updated within the last four (4) months from the renewal due month, verifications will be requested from the member.

Reasonable Compatibility Policy:

Reasonable Compatibility is a method of verification used for Medical Assistance programs that compares a member's self-attested income against income provided by an electronic data source. The agency verifies income information provided by the member through Equifax via Federal Data Service (FDSH) and/or the Work Number (TWN), and the Income Eligibility Verification System (IEVS). As part of the MA Ex Parte review at redetermination, a reasonable compatibility check will be performed to

determine whether eligibility can be approved with or without an income discrepancy notice, or a renewal packet will be sent.

Signature Policy:

Federal regulations 42 C.F.R. § 435.916(a)(3)(i)(B) and (b) and § 457.343 and State rules 10 CCR 2505 8.100.3.P.4 and 10 CCR 2505-3 140.1.B require a renewal to be signed when information through the MA Ex Parte process indicates the member may be ineligible or if sufficient information is not available to complete a redetermination process. This signature is required whether a member does or does not have changes to update to their information.

The methods for accepting the member's signature are:

1. Paper: Mail, fax, or physical drop off of the completed signature page and updated renewal form pages.
2. Online: Completing and signing the renewal through PEAK or uploading the signed signature form.
3. Telephone: Record the member's renewal attestation and have their telephonic signature recorded. This will include the rights and responsibilities being read to the member.

If a member fails to complete their renewal process because they did not provide a signature, CBMS will trigger a Verification Checklist (VCL) requesting the member's signature with the standard VCL due date. This could potentially allow a member to receive benefits for the month following their renewal due date while the VCL is pending.

A member can return the signature page as a stand-alone form or with the missing verifications requested on the VCL. If the member does not have the required verifications and returns the stand-alone signature form and all information is correct, they should check the box "I do not need to make any changes or corrections to the information." If the member has changes to report they should check the box "I need to make changes or corrections to the information," and return the renewal form with the changes and corrections.

If the member checks the box "I need to make changes or corrections to the information ", these changes can be reported to the respective eligibility site over the phone, online via PEAK, in person, mail in or fax. If the member returns the form and has not checked either box but the signature page is signed by the member, the worker

should attempt to contact the member to complete the checked box section. If the member cannot be reached the eligibility worker should not pend to complete the check boxes. As long as the signature page is signed by the member this page is considered complete.

Authorized Representative Form Policy:

A member is permitted to designate an individual or organization to act responsibly on their behalf in assisting with their renewal of eligibility per state regulation, 10 CCR 2505-10 8.100.3.A.6. The authorization form added to the renewal packet can be used to appoint an individual or organization as the member's authorized representative. The appointed individual or organization may act on behalf of the member on all duties related to their Medical Assistance eligibility and enrollment or the member may also limit duties. A member may cancel or change their appointed authorized representative at any time by contacting their local county office. The authorized representative form may be returned to a local county office in person, by mail, phone or electronically via PEAK.

Members may authorize their representatives to do some or all of the following:

- Complete and sign a redetermination form.
- Report changes.
- Receive copies of the member's notices and other communications from the agency.
- Provide the agency with information requested.

Termination of eligibility for ineligible members and reconsideration period:

Per Federal regulations, a member is allowed 90 calendar days after their eligibility has been terminated to return their renewal form and/or requested documentation. This is termed as "90-day reconsideration period." The renewal form returned within the reconsideration period serves as an application and members will not be required to submit a new application. This means the effective date of coverage will be the first day of the month in which all required documentation is received. All required documentation includes the renewal form, signature page, and any missing verifications.

If a member failed to turn in their renewal packet, missing verifications and/or signature form by the due date, the member will terminate for either "failed to complete the renewal process" or "failed to provide signature" or "missing verifications." If a case has been terminated (closed) for either of these three reasons above, eligibility workers can re-open or rescind a case under these circumstances. For Medical

Assistance programs the term re-open or rescind is used to open a case that is completely closed with no active members receiving coverage. The date used for eligibility will be the date in which all required information was provided. When rescinding a case, eligibility workers must select the "90-Day Reconsideration Period" reason in the CBMS dropdown, and the worker must enter a case comment. Per federal regulation 42 C.F.R. § 435.914, a case comment is required to provide facts that support the worker's decision as to why the case was rescinded. A worker must not rescind a case until all the required information is received. If the renewal packet is received past the 90-day reconsideration period, then eligibility workers must not rescind the case; the eligibility worker must require the applicant to submit a new application.

If a member has a gap in coverage due to turning in the renewal packet or required information after the termination date but within the reconsideration period, the member can request retro coverage up to three months. Coverage can be reinstated for those gap months as long as the member meets all eligibility requirements. If a member becomes eligible in the retro months, the retro months will not begin the renewal period. The renewal period will begin from the effective date of coverage when the renewal packet was received.

Reapply Function:

Eligibility Workers will have the ability to data enter newly submitted applications or the receipt of a late renewal packet into CBMS when a case is still in an open status. The data entry will be performed only after a member fails for "failure to return signature for renewal" or "failure to complete the renewal process." The Eligibility Worker must enter the 'failed to complete the renewal process Re-apply feature' date as of the date the packet or application is returned. If a member provides missing verifications, Eligibility Workers must select "failure to complete the renewal process" when using the reapply feature. Eligibility Workers are then required to finish the data entry of the application or late renewal packet that was received from the member.

Example: The member is terminated on 05/31/2022 and the packet is returned on 6/13/2022. The Eligibility Worker sets the 'failed MA renewal process Re-apply feature' date as of 6/13/2022. Based on the information reported in the packet, the mother is found eligible for coverage beginning 06/01/2022.

Eligibility or Data Entry Error:

When a case is terminated due to a data entry error and the Eligibility Worker corrects the error after the renewal period, the Eligibility Worker will now be allowed to "Manually Start" the renewal process in CBMS, without waiting for the Case Status to go from 'Initiated' to 'Generated'. When an Eligibility Worker rescinds a case due to data entry error, the Eligibility Worker must clean up the case so that there is no gap in coverage for the member. Cleaning up the case will require Eligibility Workers to ensure they have all the information needed to make a sufficient determination for the renewal, and/or trigger any missing verifications needed for the renewal through a VCL; this may also include the renewal packet and signature page.

Compliance & Monitoring:

Eligibility Workers, supervisors & anyone who has direct member contact must complete the mandatory training by March 31, 2022. As new workers come in, they must take the Renewal Revamp training through the web-based training.

All requirements outlined in this Operational Memo are subject to Department-level Quality Assurance (QA) reviews and Management Evaluation (ME) Reviews, after any applicable hold harmless period. In addition, all actions are subject to review by the Department's external auditors. Insufficient case comments that do not support the eligibility determination or action can result in external audit findings and may impact the Site's ME Review, when selected.

Attachment(s):

None

Department Contact:

Please contact the Medicaid Inbox with the email listed below if you have any questions. hcpf_medicaid.eligibility@state.co.us