COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

Title: Renewal Guidance for Medical Assistance Programs	**Topic:** Eligibility Policy
Audience: Eligibility Workers and Supervisors	**Sub-Topic:** Implementation
Supersedes Number: HCPF OM 23-029	**Division:** Eligibility Division
Effective Date: June 13,2025	**Office:** Medicaid Operations Office
Expiration Date: June 26, 2027	**Program Area:** Eligibility Policy
Key Words: Renewal, Eligibility, Income, Resources, Verifications, Non-MAGI, MAGI, Child Health Plan Plus	
Legal Authority: 42 CFR §435.916 and §457.343	
Memo Author: Ana Bordallo	
Operational Memo Number: HCPF OM 25-044 **Issue Date:** June 26, 2025 **Approved By:** Marivel Klueckman	

HCPF Memo Series can be accessed online: https://www.colorado.gov/hcpf/memo-series

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)) (referred to in this memo as "agency" or "agencies") with information about regulations 42 C.F.R. §435.916 and §457.34, 435.912(c)(4)(i) and §435.930(b)on completing redeterminations of eligibility for Medical Assistance members. In 2024, the Centers for Medicare & Medicaid Services published documents providing additional guidance for conducting renewals. The Department has updated policies and the Colorado Benefits Management System (CBMS) to comply with federal regulations. 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 a “Medical Assistance (MA) Ex Parte” renewal for all members (42 C.F.R. § 435.916(b)(1); 42 C.F.R. § 457.343). An MA Ex Parte renewal is a process that reassesses eligibility based on reliable information available to the agency, without needing additional information from the member. States are required to continue providing Medical Assistance to members who have submitted their renewal form and/or requested documentation before the end of the eligibility period. A member's coverage will continue until they are determined to be ineligible on all bases (42 C.F.R. § 435.930(b)).

Medical Assistance (MA) Renewal Ex Parte Process:

As part of the MA Renewal Ex Parte process, the agency is required to automatically attempt to renew a member's eligibility for MA using reliable information available. Reliable information may include data found in a member's case file, as well as more current information that can be accessed without requiring input from the member. This can include data obtained from electronic data sources, paper documents, or recently updated information from other programs, such as Adult Financial, Colorado Works, and the Supplemental Nutrition Assistance Program. Information from the initial determination at the time of application or the member’s last renewal is not considered current or reliable unless it applies to circumstances that generally remain unchanged, such as citizenship.

The MA Renewal Ex Parte process consists of CBMS identifying all renewals that will be due, when verified income is not found interfaces will be called automatically, and checking for outstanding verifications. Based on this information, the system determines whether the renewal can be approved or if a renewal packet needs to be sent to the member. If a member is approved, they can review their eligibility information used to determine their eligibility and make any necessary updates via PEAK or with their local eligibility site. If any information in the notice is incorrect or has changed, the member must notify the agency within 10 business days.

If there is not enough information available to complete the redetermination through the MA Renewal Ex Parte process, or if the agency has information indicating that a member may be ineligible or eligible in a lower benefit category, the agency must provide the member with a renewal packet and inform the member of any additional information or documentation needed to determine eligibility. A renewal packet with the most recent, reliable, and relevant information will be prepopulated and sent to the household. A member will have at least 30 calendar days (as stated in 42 C.F.R. §435.916(a)(3)(i)(B)) from the date the prepopulated renewal packet is sent to return the packet and provide any additional information requested by the agency. The renewal packet includes a signature form that must be signed and returned, regardless of whether there are any changes to report.

Verification of Income at Ex Parte:

When conducting the MA Ex Parte review, CBMS will use the most recent verified income records within the six-month look-back period, based on the "Date Verified" field, for the income calculations. This will determine whether a member will be approved or if a renewal packet will be generated.

If verified income is found, CBMS will utilize this income to determine whether the member meets the income thresholds for the evaluated MA program. If a member meets the income thresholds or qualifies for a higher benefit category, they will be able to ex parte, and an Approval Notice of Action (NOA) will be generated and sent. If a member does not meet the income threshold for the evaluated MA program or is now eligible for a lower benefit category, CBMS will generate an MA Renewal Packet, and/or Verification Checklist.

If verified income is not found, CBMS will call the interfaces to verify income. If interface income is received, CBMS will utilize the verified income to determine if the member meets income thresholds for the evaluated MA program. If a member meets the income thresholds for the evaluated MA program or can be approved in a higher benefit category, the member will ex parte, and an Approval Notice of Action (NOA) will be generated and sent. If a member does not meet the income threshold for the evaluated MA program, or can be approved in a lower benefit category, CBMS will generate an MA Renewal Packet. The renewal packet provides members with the opportunity to review their information and report any necessary changes. If the member fails to report any changes to their income, CBMS will use the income verified at ex parte to make a final determination. It is the eligibility worker's responsibility to update all reported information, including any changes to income. Lastly, if the interface income is not received, it will be assumed that the member has no earned income, and zero earned income will be counted for the member at ex-parte to make a final determination.

Reasonable Compatibility at Renewal:

Reasonable compatibility will no longer apply when verifying eligibility during the MA Renewal Ex Parte process, as the agency does not have newly self-attested income from the member to compare with the electronic data obtained by the agency. When the member is found ineligible based on the electronic data obtained and exceeds the applicable income threshold, the agency will send the member an MA Renewal Packet, and/or Verification Checklist to redetermine eligibility.

Reasonable Compatibility for new applications and newly reported income:

As mentioned above, reasonable compatibility will no longer apply during the MA Renewal ex parte process. However, it will still apply to new applications and changes in reported income. According to 42 C.F.R. §§ 435.952(b) and (c) and 457.380(e) and (f), reasonable compatibility is defined as the acceptable difference between a member's self-reported income and the income reported by an electronic data source. Reasonable compatibility is used to determine whether further clarification is needed from the member to verify their self-reported income. An income discrepancy occurs when a member's self-reported income falls below the income standard for the Medical Assistance program, while the income reported through an electronic data source exceeds that income standard. Additionally, the difference between the two reported amounts must be greater than the reasonable compatibility threshold percentage of 20%. When a member reports new income, this income will be verified during ongoing mode to determine if it is reasonably compatible.

Signature Policy:

Federal Regulations 42 C.F.R. § 435.916(a)(3)(i)(B) and (b) and § 457.343, along with State rules 10 CCR 2505 8.100.3.P.4 and 10 CCR 2505x-3 140.1.B, require a renewal signature when information from the MA Ex Parte process suggests that the member may be ineligible or if there is insufficient information available. This signature is necessary regardless of whether a member has any changes to their information or not.

A member’s signature may be captured in the following ways:

1. **Paper Submission**: By mailing, faxing, or physically dropping off a completed and signed signature page, along with any updated renewal form pages.
2. **Online Submission**: By completing and signing the renewal through the PEAK portal or uploading a scanned or photographed copy of the signed signature page.
3. **Telephonic Signature**: By providing verbal attestation during a recorded phone call, during which the member's rights and responsibilities are read and acknowledged.

If a member fails to complete their renewal process due to a missing signature but has attempted to return the renewal forms, CBMS will trigger a Verification Checklist (VCL), applying the standard VCL due date. This may allow a member to remain eligible for benefits while the VCL is pending.

A member can return the signature page as a standalone form or along with the missing verifications requested on the VCL. If the member does not have the required verifications and returns the standalone 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 submits the form without checking either box but has signed signature page, the eligibility worker should attempt to contact the member to clarify and complete the "changes or corrections" section. If the member cannot be reached, no additional documentation should be requested or pended solely to complete the checkbox section. A signed signature page is sufficient and considered complete.

For combo cases that include both a CDHS program and a MA program under one active case, a signature on the SNAP renewal form is acceptable for the MA renewal if the signature is the only missing document. If the member submits a new Public Assistance Application (SPA) instead of a SNAP renewal form, the SPA application can be used to complete an MA renewal. If the MA Renewal Ex Parte process has already begun for a combo case, the case must still be reviewed and processed separately to determine MA eligibility and confirm that the member has submitted all required verifications.

Authorized Representative Form Policy:

A member may designate an individual or organization to act on their behalf in assisting with their MA renewal and maintaining MA eligibility, per state regulations, 10 CCR 2505-10 8.100.3.A.6. The authorized representative form included in the renewal packet can be used to appoint an authorized representative. This representative may act on behalf of the member in all duties related to their MA eligibility and enrollment, or the member may choose to limit those duties. A member can change or revoke their appointed authorized representative at any time by contacting their local county office. The completed authorized representative form may be submitted in person, by mail, by phone, or electronically through PEAK.

Members may authorize their representatives to perform some or all of the following tasks on their behalf:

- Complete and sign a redetermination(renewal) form.
- Report changes based on the member's circumstances.
- Receive copies of notices and other official communications from the agency.
- Provide requested information to the agency.

Reinstatement of Coverage:

In accordance with Federal Regulation 435.930(b), if a member submits their renewal form or any additional required documentation before the end of their renewal period, the agency must continue the member's coverage under their most recent MA aid code. Coverage must remain active until an eligibility worker determines that the member is either ineligible on all bases or has failed to provide the necessary documentation within the required timeframe. If a member is disenrolled before a final determination is made, their coverage must be reinstated immediately and maintained until the final determination is completed.

CBMS has added new fields in the Program Action screen to help identify when a member submits a renewal form and/or additional documentation before the end of their renewal period. The eligibility site must complete the Program Action screen and enter the "Renewal Paperwork Received Date" field. Once entered, CBMS will auto-populate the "Renewal Paperwork Data Entry Date" and the "Program Group (Medical Assistance)" fields.

Automatic Reinstatement Process:

If the eligibility site completes the "Renewal Paperwork Received Date" field before the 15th of the renewal due month, CBMS will automatically maintain the member's coverage. The case will remain in "Pending Status" until the eligibility worker makes a final determination. The Case Wrap-Up screen will remain marked as "No" until the caseworker changes it to "Yes". When a member's coverage is automatically maintained, an MA Reinstatement Speed Letter is generated and sent to the household. This letter identifies all members whose coverage has been automatically reinstated and informs the household that coverage will continue while the renewal is under review.

If the MA program has been discontinued for a member, and the member submitted the renewal form and/or additional documentation before the end of their renewal period, the eligibility site must complete the Program Action screen and enter the "Renewal Paperwork Received Date" field **on or before the last day of the month following the month** in which the MA renewal is due, for CBMS to automatically rescind or use the reapply function to restore a member's coverage. A member will be reinstated into their most recent aid code. The Case Wrap-Up screen will automatically change to Case Complete "No" until the eligibility worker changes it to "Yes". When a member's coverage is automatically reinstated, an MA Reinstatement Speed Letter is generated and sent to the household. This letter identifies all members whose coverage has been reinstated and informs the household that coverage will continue while the renewal is under review. When an eligibility worker is processing a renewal packet or verification the eligibility worker will complete the appropriate data entry fields and update the data entry complete field to "Yes." Workers must complete the Edit RRR Details Screen to enter the 'Renewal Received

Date' and the RRR 'Signature Provided' field. The RRR 'Signature Provided' field is required for an MA Renewal to be considered complete.

Example, the member has a renewal due on September 30, 2025, and submitted renewal documentation on September 10. CBMS terminated the member's coverage on September 15 because there was no indication that renewal documents had been received. The eligibility site has until October 31 to complete the Program Action screen for CBMS to automatically rescind or use the reapply function to reinstate a member's coverage.

An exception applies when sending the MA Reinstatement Speed letter. If the eligibility worker completes the Program Action screen and finalizes the renewal process on the same day, the household will not receive the MA Reinstatement Speed letter. Instead, the member will receive either an Approval or a Termination Notice of Action (NOA) that informs them of their final determination.

When a member reports information through PEAK and the MA renewal is in a "Started" status, or if the Program Action fields have been completed during the renewal process, all Report My Changes (RMC) will not trigger a case to run Real-Time Eligibility (RTE) for MA programs. Instead, these reported changes will be routed to the CBMS PEAK inbox for the eligibility worker to review and process manually.

Manual Reinstatement Process:

If the MA program has been discontinued for a member, and the member submitted the renewal form and/or additional documentation before the end of their renewal period the eligibility worker must reinstate the member's coverage. If the eligibility worker completes the Program Action screen **after the last day of the month following the MA Renewal month**. The worker will see the following error message: " You are past the window to edit this field, made one month after the MA Renewal Due Date." As a result, these records will not be saved in the Program Action screen, and CBMS will not automatically apply the reinstatement process. The eligibility worker must manually rescind or use the reapply function to restore the member's coverage. Once this manual process is completed, the member will be reinstated into their most recent aid code. Members who manually get reinstated will not receive an MA Reinstatement Speed letter.

Example, the member has a renewal due on September 30, 2025, and submitted renewal documentation on September 10. CBMS terminated the member's coverage on September 15 because there was no indication that renewal documents had been received. If the eligibility site completes the Program Action screen in November, the case will need to be manually rescinded, or the reapply function will be used to reinstate the member's coverage.

Security Profiles for Program Action Screen:

Users of the Colorado Benefits Management Systems (CBMS) with the security profiles 110-RRR-Update and 111-RRR-Inquiry will have updated access to all fields on the Program Actions screen for Medical Assistance. Eligibility sites will need to incorporate this new step into their business processes when completing renewals.

Timely Processing for Renewals:

Federal regulation 435.912(4) specifies that eligibility sites have 30 calendar days to complete a renewal determination for members who submit their renewal form and/or documentation. The section on Redetermination of Eligibility in 10 CCR 2505-10 8.100.3.P has been updated. If the submitted information is incomplete or if a member reports any new changes, the eligibility site must contact the member, either by phone or in writing, to request the necessary documents or verifications. If additional verifications are needed, the eligibility site is responsible to send a form along with a letter explaining which items need to be completed through CBMS. The member is then required to return the completed request form to the eligibility site within 10 business days. Once the eligibility site receives the necessary documents, it has 15 working days to make a final determination, starting from the Verification Received Date, to review, process, and finalize the verification. This timeline includes checking that the documentation is complete, as well as addressing any outstanding issues to determine eligibility.

Timely and Performance Standards for Renewals:

MA Renewal Timeliness is monitored for compliance solely through the Medical Assistance Performance (MAP) Dashboard. The MAP Dashboards provide detailed information regarding actual performance, targets, benchmarks and accurate measures to ensure compliance with performance expectations.

The MAP Dashboard will take a phased approach to compliance and incentive contract scoring, incorporating the new timeliness guidelines. The current timeliness guidelines will be applied to all renewals authorized through December 31, 2025. If no packet is received, or if the packet is received before the 15th of the renewal due month indicated in CBMS, the renewal will be considered timely if authorized by the last day of the renewal due month shown in CBMS. Should the packet be received on the 15th of the renewal due month indicated in CBMS or later, including any time during the 90-day reconsideration period, the renewal will be deemed timely if authorized within 30 days of the date the packet was received.

Beginning with renewals authorized on January 1, 2026, and thereafter, the MAP Dashboard will adhere to the guidance provided by CMS for timeliness, based on federal regulation 435.912(4). When an eligibility site receives a renewal form and/or

documentation with at least 30 calendar days remaining in a member's current eligibility period, it must authorize the renewal before the eligibility period ends for it to be considered timely. If the eligibility site gets a renewal form with fewer than 30 calendar days left in the current eligibility period, it must authorize the renewal by the end of the following month for it to be considered timely.

90-Day Reconsideration Period:

Per federal regulations, a member has 90 calendar days after their eligibility is terminated to submit their renewal form and/or any requested documentation. This is known as the “90-day reconsideration period.” A renewal form and/or any requested documentation submitted within the reconsideration period is treated as an application, and members will not need to submit a new application. If a member fails to submit their renewal packet, including missing verifications and/or a signature form by the due date, the member will be terminated for one of the following reasons: “Failure to complete the renewal process” or “Failure to return signature for renewal” or “Failed to provide verification at renewal.”

Coverage will begin on the first day of the month based on when the documentation is received. The types of documentation include the renewal form, signature page, and any required verifications that are missing. Members are not required to submit all necessary documents for the eligibility worker to either rescind or utilize the reapply function during the 90-day reconsideration period. If any documents are still missing when a case is being evaluated during this period, the member may be terminated for one of the following reasons: "Failure to complete the renewal process, "Failure to return the signature for renewal," or "Failure to provide verification during renewal.".

Please note that the 90-day reconsideration period policy is different from the reinstatement process policy. The 90-day reconsideration period applies to members whose benefits have been terminated due to the member not submitting any renewal documentation by the end of the renewal period. In contrast, the reinstatement process is for members who have submitted renewal documentation before their renewal period ends.

During the 90-day reconsideration period, an eligibility site has 30 calendar days to process the renewal form and verify information once it is received. Eligibility sites are responsible for processing MA renewals and ensuring that eligibility is determined accurately.

Rescinding:

If the case has been terminated (closed) for any of the reasons listed above, eligibility workers can reopen and rescind a case under these circumstances. For MA programs, the term reopen or rescind is used to indicate the opening of a case that is

completely closed, with no active members receiving coverage. The eligibility date will be the date when the information was provided.

When rescinding a case, eligibility workers must select the "90-Day Reconsideration Period" reason from the CBMS dropdown menu and enter a case comment. According to federal regulation 42 C.F.R. § 435.914, a case comment is necessary to provide facts that support the worker's decision on why the case was rescinded. If the renewal packet is received after the 90-day reconsideration period, the member must submit a new application.

Reapply Function:

Eligibility Workers will have the ability to enter newly submitted applications or the receipt of a late renewal packet into CBMS when the case remains in an open status. Data entry will occur 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.

Retroactive Coverage:

If a member submits their renewal packet or required information after the termination date but within the reconsideration period, they may request retroactive coverage for 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 for retroactive coverage, the retroactive months will not be included in the renewal period. The renewal period will begin in the month when the renewal packet is received.

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 has ended, 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 a data entry error, the eligibility worker must ensure the case is updated correctly to prevent any gap in coverage for the member's coverage. This includes verifying that all necessary information is available to make a complete renewal determination and issuing a Verification Checklist (VCL) if any required documentation is missing. Cleanup may also involve obtaining the renewal packet and a signed signature page, if one has not already been provided.

Compliance & Monitoring:

Eligibility workers, supervisors, and anyone with direct member contact must complete the updated web-based trainings: RRR/Renewal Basics, Medical Assistance Renewals, and the MA Rescind or Reapply. Additional resources can be found on the Health Care Policy and Financing (HCPF) website. These resources include the updated MA Renewal FAQ, the Medical Assistance Renewal Workbook, and Operational Memo Number: HCPF OM 25-018.

All requirements in this Operational Memo are subject to Department-level Quality Assurance (QA) reviews and Management Evaluation (ME) reviews, following any applicable hold harmless period. Additionally, all actions are subject to review by the Department's external auditors. Inadequate case comments that do not support the eligibility determination or action may lead to external audit findings and may affect the Site's ME review when selected.

Action To Be Taken:

Eligibility sites should ensure that when renewal cases are being processed in CBMS that they are receiving accurate eligibility determinations based on these new policy and system updates effective July 1, 2025 for September renewals. Eligibility sites should also refer to rules under 10 CCR 2505-10 section 8.100.3.P and 10 CCR 2505-3 sections 140 for additional renewal policy.

Attachment(s):

None

HCPF Contact:

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