1502-1

COMBINED MEDICAID RENEWALS

Supersedes: CMA 1502-1 (04/01/2023)

Reference: 42 CFR 435.916,.919; ARM 53.6.142, .205, .206; P.L. 111-3

Overview: All Medicaid cases must be renewed at least annually. A renewal consists of reviewing both financial and non-financial eligibility factors to determine ongoing eligibility. A timely closure notice is mailed if the updated information is not received by the due date. Appropriate notices must be sent when a renewal is completed. See CMA 1503-1 Timely and Adequate Notice.

Interviews cannot be required to complete a renewal. However, if the client requests an interview, it must be scheduled.

SSI Recipients: The Social Security Administration completes an SSI recipient's annual Medicaid review. A renewal is not required if the individual is receiving or requesting additional coverage, such as Nursing Home, Waiver, QMB or SLMB and SSI/State Supplement is verified via SDX interface (IN).

ACA/ABD/Family Medically Needy: Renewed annually. All available electronic data sources are automatically queried; if there are no discrepancies between the queried and existing data, the program is automatically renewed. An approval notice is sent letting the household know benefits will continue. If a discrepancy is discovered or the auto-renewal process cannot run, a pre-populated renewal form is mailed to the household, allowing at least 30 days for the form to be returned. The client is required to respond and provide necessary information; they must either return the signed renewal form, or process the renewal online, via the PAHL or in person.

Medicaid eligibility is redetermined:

1. Annually,

2. Periodically when a time-limited circumstance changes (e.g., conditional assistance period ends, intent to return home period ends, etc.).

Available queries will be run as a part of the review. If the recipient/household reports a change at renewal that may be verified by use of an available query or matches reasonably to current information available in the case file, no further verification is requested from the client.

Client's self-attested income is required to be electronically verified at renewal.

PEV Returns:

- Within 10% compatibility = authorize the ACA Benefits and do not request verification.
- Outside 10% compatibility = obtain a reasonable explanation from the household (e.g., job end, decreased work hours, increased pay), authorize benefits.

Reasonable compatibility:

- Asset Verification System (AVS) – If the information returned from AVS, along with other countable resources are at or under the resource limit for the program evaluated, no further verification is requested from the client and benefits can be redetermined.

If the attempt to obtain a reasonable explanation is unsuccessful or the reported change can't be verified, hard copy verification of the change is required. When verification is not submitted with the reported change, a request for information will be sent. If the requested information is not submitted, benefits will be terminated.

If the reported change could result in a negative action, as a courtesy, send a request for information if timely notice of adverse action would still be possible by the due date on the notice. If timely notice would not be possible by the due date of the request for information notice, benefits will be closed using timely notice. Include in the comments section of the negative action notice that if verification is received before the effective date of closure, the information will be used to reconsider eligibility.

EX-PARTE REVIEWS:

Part of the renewal process is to complete an exparte review for any Medicaid client whose current Medicaid coverage is ending at renewal for reasons other than failure to comply. See 'Ex-Parte Review' in CMA 103-1 Application Processing for more information.

Effective Date: November 1, 2024