



COMBINED MEDICAID 1502-1 Renewals

Supersedes: FMA 1502-1 (03/01/12); ABD 1502-1 (03/01/12)

Reference: 42 CFR 435.916 and .919, ARM 37.82.101, .205, .206 and 37.83.201; 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 10 day. Appropriate notices must be sent when a renewal is completed. See CMA 1503-1.

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

See CMA 1501-1 for change reporting and verification policy.

SSI Recipients: The Social Security Administration completes an SSI recipient's annual Medicaid review. However, if the individual is receiving or requesting additional coverage, such as nursing home, waiver, QMB or SLMB, the eligibility staff member must complete that review.

ACA: 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.

ABD and Family Medically Needy: Medicaid eligibility is redetermined:

1. At least annually
2. At the time of a known change;
3. When a change is reported or discovered; and
4. Periodically when a time-limited circumstance changes (e.g., conditional assistance period ends, intent to return home period ends, etc.)

Automatic renewals are not available for ABD or Family Medically Needy, therefore a pre-populated renewal form is mailed to the household, allowing at least 30 days for the form to be returned. The

household/recipient is required to review the information on the form, and only report to the OPA changes to the information.

If the recipient/household has no changes to report, they are not required to contact, communicate with or verify information to the OPA. No contact from the recipient is to be interpreted to mean “no change in circumstances.”

If the recipient/household reports changes that will not impact on-going benefits (change the level of coverage), no verification of changes is required.

If the recipient/household reports changes that will potentially impact on-going benefits (reduction in level of coverage, termination, increase in benefits), verification of the change is required. When verification is not submitted with the reported change, and the reported change could result in an increase in benefits to the recipient/household, a request for information will be sent. If the reported changes could result in a negative action, send 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 on 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.

Available queries will not routinely be reviewed as part of the administrative review. However, if the household reports a change that may be verified by use of an available query, that query can be used to verify the change.

EX PARTE REVIEWS:

Part of the renewal process is to complete an ex parte review for any Medicaid client whose current Medicaid coverage is ending at renewal. See ‘Ex Parte Review’ in CMA 103-1 for more information.

Effective Date: July 01, 2016