101.16 THE REDETERMINATION OR RENEWAL PROCESS

Redetermination is the process of verifying whether a recipient continues to meet the eligibility requirements of a particular program. Redeterminations are classified as either regular or special reviews.

A regular review is an annual review of all eligibility factors that are subject to change. A special review is completed when a portion of the case must be re-worked or case information must be updated because of a change. This chapter addresses the redetermination process.

101.16.01 REGULAR REDETERMINATIONS OR RENEWALS – MAGI & ABD

Federal regulations require that the eligibility of every Medicaid and CHIP recipient be reviewed at least every 12 months. Mississippi state law also requires annual reviews. During the regular redetermination process, the recipient's circumstances are reviewed and each eligibility factor that is subject to change, such as income and/or resources, is re-evaluated. Recipients are not asked to provide information that is not relevant to ongoing eligibility or that already been provided and is not subject to change.

101.16.01A FREQUENCY OF REVIEWS

A full review must be conducted for all eligible household members (MAGI and ABD) at the earliest 12-month review when case members have different review due dates. When a redetermination is currently due for some but not all case members, a redetermination contact will be set on everyone to *attempt* to align redetermination dates for the following year and assure one annual review for case members:

- Adults in the case can have their 12-month review period shortened by a change in circumstances that affects adult(s) in the case. The exception is a pregnant adult who is eligible in COE-088.

- Children that are not due for review require special handling to ensure protection of their 12-months of continuous eligibility, as described in 101.16.01B and 101.16.01C below.

101.16.01B PROCESSING CHILDREN CURRENTLY DUE FOR REVIEW

If a child, currently due for review, is determined ineligible or will have a program change from Medicaid to CHIP or vice versa, the action must be effective at the end of the current 12 month review period. To process the termination or change in the system, the specialist will enter the month following the child's review due month as the time span begin date.

Example: The child's review due date is May. The time span begin date is set for June. If timely action is taken by the adverse action deadline in May, a termination will be effective May 31st. If a program change is involved, action must be taken prior to the end of May.

101.16.01C PROCESSING CHILDREN NOT CURRENTLY DUE FOR REVIEW

Each child must be provided 12 months of continuous eligibility in his eligible category. Prior to the end of the 12-month period, a child cannot be:

- Terminated, unless an early termination reason exists, or
- Changed from one program to another (Medicaid to CHIP or vice versa) unless the parent or other authorized person voluntarily requests early closure in the current program or the original determination was in error.

When reviewing a case with different review due dates and the current review is for the person with the earliest review due date, it is appropriate to set a redetermination contact for all case members; however, the current review and any requests for information must be focused on the case member(s) due for review. Do not request any information on any *children* with a future review due date. If updated information is provided during the review which results in eligibility for all case members, eligibility can be extended for all members, including children with a future review due date.

If updated information results in ineligibility for any child with a review due date in the future, it is not possible to take action to terminate eligibility prior to the end of the 12-month continuous period. Future termination dates for children not currently due for review are not permitted. Instead, the child or children must be fully reviewed at the end of the 12-month protected period of eligibility. This includes a deemed eligible newborn who is eligible for the first full year of life. Retract eligibility and cancel the redetermination contact for any children affected by a finding of ineligibility.

PROCESSING CHILDREN NOT CURRENTLY DUE FOR REVIEW (Continued)

When a program change is involved for a child with a future review date, the change cannot be made until the end of the child's current eligibility period unless the parent or other authorized person voluntarily requests early termination in the current program. The request must be made in writing by the parent or other authorized person and filed in the case record.

Retract eligibility and cancel the redetermination contact for any children affected by a program change that has not been approved in writing

101.16.01D PROCESSING AN APPLICATION AND A REVIEW

As previously indicated, when an application is filed to add a new child or adult (MAGI or ABD) to an active case, a review is completed for existing case members at the same time the application for the new member is processed. However, the same policy requirements apply for an application and a review as exists for processing an active case with children not currently due for review:

- Do not request any information on any children with a future review due date.
- If updated information is provided for the applicant that results in eligibility for all case members, eligibility can be extended for existing case members, including children with a future review due date.
- If updated eligibility results in ineligibility for any child with a future review due date, the child or children must be fully reviewed at the end of their 12-month protected period.
- A program change for a child with a future review date is prohibited unless the parent or other authorized person requests early termination in the current program.
- If a finding of ineligibility or a program change results for existing children in the case who are not due for review, retract eligibility and cancel the redetermination contact for the child(ren) with a future review due date.

101.16.02 ASSIGNMENT OF REVIEW DUE DATES

A regular review must be completed on each recipient at intervals not to exceed 12 months. The system automatically sets a 12-month review at application and redetermination as follows:

APPLICATIONS	REVIEWS
MAGI applications – a Medicaid application month starts the 12-month count. (Application month + 11 months = review due date.) For CHIP, the benefit month starts the 12-month count (Month after month of application + 11 months = review due date.)	MAGI and ABD review due dates are determined using the time period begin month to start the 12-month count. (Begin month of time period + 11 months = review due date.)
ABD applications – the month the supervisor authorizes eligibility starts the 12-month count. (Supervisor authorization month + 11 = review due date.)	

The reviewing supervisor is responsible for ensuring the proper review due date is assigned to each individual and for correcting or adjusting system-assigned dates at authorization when needed. No individual's review due may be adjusted to exceed 12 months.

Setting Correct Time Spans to Ensure a Child's 12-Months Continuous Eligibility

Because children (MAGI or ABD) can be added to a case at different times (birth of a child or addition of a child to a case), not everyone within a case may have the same review due date. As stated previously, all children under age 19 (MAGI and ABD) are entitled to 12-months of continuous eligibility.

The system sets the review due date based on the beginning month of the time period entered. When completing MAGI and/or ABD redeterminations, the time period must be set as follows:

ASSIGNMENT OF REVIEW DUE DATES (Continued)

Overdue for Review	Set the time span for the month following the month the pre-populated renewal form is received. Children who are approved will have a new review due date 12 months from the time period begin date. Ineligible children must have a full review at the end of their 12-month protected period.
Current Reviews	Set the time span for the month following the earliest redetermination due date for the case. This is the starting point to begin the eligibility assessment. If all children are approved again in the same program, the new review dates will be 12 months from the time period begin month.
Early Reviews	Begin the time span with the month following the earliest redetermination due month for the case. This is the starting point to begin the eligibility assessment. If all children are approved again in the same program, the new review dates will be 12 months from the time period begin month. If a program change or termination results, it will be necessary to adjust the time spans of children with future review dates to allow 12 months of continuous coverage prior to termination or program change. When caseload adjustments are needed to equalize the number of reviews due the following year, it is also permissible to set the time span for an early review to begin the month following the month the renewal form is received. The case should be documented when this action is being taken.

101.16.03 ADMINISTRATIVE RENEWALS

An administrative renewal allows eligibility to be renewed based on reliable information contained in the case record and other more current information available to the regional office, such as current data secured from electronic data sources.

- An administrative review must be attempted on every case due for review except ABD cases with a resource test. ABD Medicare cost-sharing cases are renewed administratively, if possible. Exception: if eligibility for QMB, SLMB or QI was initially based on approval of an LIS application, the first annual review must be a full review via the pre-populated renewal process. After the first full review, attempt an administrative renewal for each subsequent review of a Medicare cost-sharing case.

- An administrative review is ***required*** annually for SSI-only cases in Long Term Care in COE-005. SSI-only reviews must be completed or, at a minimum, a redetermination contact must be registered, prior to the scheduled mailing of a pre-populated renewal form for the SSI-only case to prevent a pre-populated renewal form from being issued. For SSI-only reviews, the action needed is to verify the individual remains in the facility, check the SDX for any changes and attempt verification of any resources, such as a patient account or other type(s) of resources available to the SSI recipient.

- An administrative review is processed without contacting or requiring information from the MAGI household or Medicare cost-sharing recipient(s). If there is no known change in household circumstances and if all reported income types and sources can be verified through available electronic data sources, use current income verification from these sources to renew eligibility.

- If a MAGI or Medicare cost-sharing case can be *approved* using current information verified through electronic data sources, the recipient is notified of the approval. A pre-populated renewal form is not generated for administrative renewals.

ADMINISTRATIVE RENEWALS (Continued)

- If an administrative review does not result in an *approval in the same program,* a pre-populated form must be issued to allow the recipient to provide current information. It is possible to move a child from one Medicaid program to another Medicaid program based on an administrative review; however, a child cannot go from Medicaid to CHIP or CHIP to Medicaid.

- If a MAGI or Medicare cost-sharing recipient reports a change in response to an administrative renewal approval, document all changes on the "Administrative Review Contact Documentation" form located in the Appendix page by the same name. Attempt verification of a reported change through electronic data sources before requesting information directly from the recipient.

- Handle reported changes as a redetermination contact in the system. The appropriate approval or denial notice will be issued based on the outcome of the reported change.

- Automated mailings of pre-populated review forms take place on a schedule that is published annually and is based on the review due month. Administrative renewals must be registered as a redetermination contact with a time period pending *before* the scheduled mailing of a pre-populated form.

Every regional office must have a process in place to ensure administrative renewals are attempted as required prior to the scheduled mailing date for the system to issue a pre-populated review form.

101.16.04 PRE-POPULATED RENEWALS

If a renewal of eligibility cannot be accomplished by an administrative review, a pre-populated review form is issued to the recipient displaying the information that is available to the agency. The renewal form is an initial request for information. Renewal due dates are included on the form which provides the recipient with time to respond and provide any necessary information specified on the form that is needed to renew eligibility. Renewal includes returning the signed renewal form. Renewal due dates are as follows:

- MAGI-related renewals have 30-days from the date the renewal form is issued;

- ABD renewals have 20-days plus time allowed for the issuance of a DOM-309, Second Request for Information, if needed.

The signed form and any paper verifications may be returned to the Division of Medicaid through any of the methods permitted for submission of applications.

MAGI pre-populated renewals are issued with known household composition and demographic data, current income information, tax and dependent status of each known household member and information on any health insurance coverage for household members. There is space on the form for the head of the household to make any needed changes to information reported on the form.

ABD pre-populated renewals are issued with known demographic and income information for each eligible individual or couple. There is space on the form for the individual or couple to make any needed changes to information reported on the form.

- Pre-populated renewal forms are issued by the system in advance of the renewal month based on the following timelines:

    - MAGI renewals are issued 1-month in advance of the review due month. For example, December reviews are mailed on 11/01 and are due 11/30.
    - ABD renewals are issued 2-months in advance. For example, December reviews are mailed on 10/01 and are due 10/21.

PRE-POPULATED RENEWALS (Continued)

- The case must have no open contacts or pending time periods by the published deadline in order for the system to generate a pre-populated renewal form. Any cases that are not in the appropriate status as of the date of mailing will be by-passed by the system making it necessary for the specialist to issue a pre-populated renewal form manually. If a renewal form is issued manually, the specialist must pre-populate the form will all known information required by the renewal form.

- If a returned MAGI form is incomplete, meaning there is missing information or verification needed, attempt a telephone contact with the head of household to explain what is needed. For ABD incomplete renewals, use DOM-309 to request any missing verification(s).

- If a returned form results in the reporting of new or additional information that was not previously reported and verification of the information is not possible for the regional office to obtain:
    - For MAGI cases, attempt a telephone contact to request the needed verification. If contact is unsuccessful, issue DOM-307 requesting the new or additional needed information in writing.
    - For ABD cases, use DOM-307 and, if needed, DOM-309 to request any new or additional information.

- If a renewal form (MAGI or ABD) is not returned by the due date, attempt telephone contact with the recipient as a reminder that the form is due for completion and return to the regional office via mail, in-person or electronically.

- When the ABD or MAGI recipient or head of household fails to provide all needed information, action cannot be taken to terminate eligibility due to failure to provide information without first attempting a telephone contact to inform the individual of the information needed and when it must be provided to prevent termination. All efforts to contact the individual must be documented in the case record.

- Monthly and Weekly Redetermination Due Listings for both ABD and MAGI cases are available in the system to track and monitor cases due for review. Cases that are overdue for review are also part of these reports.

- If needed information is provided after the applicable due date for renewal, refer to 101.16.12 "Requested Information Provided After Closure."

101.16.05 RETURNED MAIL FROM REDETERMINATIONS

When an administrative approval notice or a pre-populated review form is returned by the post office, handle as follows:

- If mail is returned with a forwarding address, attempt a telephone contact to confirm the address. If a telephone contact is not successful or possible, update the address and re-route the mail. Document all contact attempts.

- If mail is returned without a forwarding address, attempt telephone contact(s) with the household to determine the current address. If all reasonable attempts to contact the household are exhausted and the current address cannot be obtained, terminate eligibility due to "unable to locate."

- If the current address is subsequently obtained for an administrative review approval and it is determined the basis of eligibility in the administrative review was otherwise correct, i.e., no household or income changes, recipients may be reinstated with no loss of benefits if within 90 days of the date of closure. If new income or household information is reported, use the "Administrative Review Contact Documentation" form to collect information. If verification is needed, attempt to obtain it through available electronic data sources before requesting information from the recipient(s). Use a redetermination contact to conclude the review in the system.

- If the current address is subsequently obtained for a returned pre-populated form within 90 days of the date of closure, issue the form to the current address and allow 30 days for the form to be returned.

101.16.06 TIMELY PROCESSING

It is important for redeterminations to be completed in a timely manner to prevent overdue cases. Since a recipient's eligibility does not expire, benefits continue until the agency completes the review and an eligibility decision is made to either approve or terminate coverage. A review becomes overdue when more than 12 months have passed since the last eligibility determination. It is the responsibility of regional office staff to ensure reviews are processed timely.

When to Begin Processing a Review

It is permissible to begin the review process as early as the 10th month of a 12-month eligibility period or no more than 2 months early. However to ensure timeliness, the review process must begin no later than the month prior to the review month. This means for a case with a review due date of August, the redetermination process may begin as early as June, but must begin no later than July.

101.16.07 TIMELY AUTHORIZATION

The approval of a Medicaid redetermination is timely if it is authorized by the last day of the month in which the review is due. If Medicaid or CHIP benefits are terminated, the action must be authorized no later than the adverse action deadline in the review month to be effective the following month.

When a redetermination closure is not authorized by the adverse action deadline in the review month, the case or individual is out of certification. However, an improper payment report is not required for the untimely closure. Ineligibility must exist for another reason for an improper payment report to be prepared.

Adverse Action Deadlines

The adverse action deadline is the 15th of the month in order to allow 10-days advance notice plus 5 days mailing time. Action must be taken by the adverse action deadline in the review month if coverage is to be terminated at the end of the review month.

If Medicaid or CHIP termination action is authorized by the 15th of the month in which the review is due, the termination is effective at the end of the review month. An exception is February when the adverse action deadline is the 13th.

NOTE: Adults are not guaranteed 12 months of coverage. If termination is appropriate, the specialist will take action to terminate an adult's eligibility for the earliest possible month. However, coverage must be terminated no later than the adverse action deadline in the last month of the review period for the redetermination closure to be timely.

101.16.08 EXPARTE REVIEWS

Any recipient under review who is losing eligibility in one category of assistance is entitled to have eligibility reviewed and evaluated under any/all available coverage groups. The term "exparte review" means to review information available to the agency to make a determination of eligibility in another coverage group without requiring the individual to come into the office or file a separate application.

When to Complete an Exparte Determination

For an exparte determination to be made, the specialist must be in the process of making a decision on a current application, review or reported change. If the specialist is denying or closing for failure to return information or failure to complete the review process, an exparte determination is not applicable.

> **Example:** Jane Doe's CHIP eligibility will terminate because the family reports she is now covered under other health insurance. The specialist must review the record to see if it contains information which indicates the child has potential eligibility under another coverage group.
>
> **Example:** Recipient Tom Smith failed to comply with the annual review requirement and his eligibility must be terminated. The specialist does not complete an exparte determination.

Basis for the Exparte Review

The decision of whether the recipient is eligible under a different coverage group must be based on information contained in the case record. This may include income, household or personal information in the physical record which indicates the ineligible adult or child has potential eligibility in another coverage group. It also includes information received through electronic matches with other state/federal agencies such as a disability onset date or prior receipt of benefits based on disability.

Obtaining Information to Make the Determination

When potential eligibility under another coverage group is indicated, but the specialist does not have sufficient information to make an eligibility determination, the recipient must be allowed a reasonable opportunity to provide necessary information.

EXPARTE REVIEWS (Continued)

Using DOM-307, the specialist will ask the recipient to provide verifications needed to determine eligibility in the new category. If the individual is an ABD recipient potentially eligible in an MAGI category or vice versa, the request will include completion of the appropriate application form to collect required program information. An in-person interview is not conducted in the exparte review process even for a program that normally requires an interview.

Eligibility Decision

If the individual is subsequently determined to be eligible in the new category, the approval must be coordinated with termination in the current program to ensure there is no lapse or duplication in coverage. However, if requested information is not provided or if the information clearly shows that the recipient is not eligible under another category, eligibility in the current program will be terminated with advance notice.

During the advance notice period, the recipient is allowed time to provide all requested information to determine eligibility in the new program, provide information which alters the decision to terminate benefits in the current program or request a hearing with continued benefits. The specialist must take prompt and appropriate action to reinstate benefits when the recipient either provides all requested information needed to determine eligibility in another category, provides information which changes the termination decision in the current program, or requests a hearing with continued benefits during the advance notice period.

NOTE: When the recipient is determined ineligible in the new category, he does not have to repay the benefits he received while the eligibility determination was in process. However, if benefits are continued pending a fair hearing decision and the outcome is not favorable to the recipient, he is liable for repayment of the cost of services furnished solely because of the continuation of benefit provision.

Requested Information Provided After Closure

If the recipient subsequently provides all of the information needed to assess eligibility in the new program within 90-days of termination, the case should be handled in accordance with "Requested Information Provided After Closure," described in 101.16.12.

EXPARTE REVIEWS (Continued)

Example: A CHIP review is due in May. On May 10th, the specialist determines the children's eligibility will terminate because of excess family income. She completes an exparte review of the case record and notes the SVES response for one child indicates the child has prior SSI eligibility. Since information available to the agency indicates a potential disability for this child, the specialist determines the child must be evaluated for another coverage group before her CHIP eligibility can be terminated. Since the exparte review does not indicate potential eligibility in any other coverage group for the other children, the specialist completes the closure action for them, leaving eligibility open for the potentially eligible child. She documents the case to support the action.

The specialist issues a 307 requesting a completed ABD application form and other information to determine Medicaid eligibility based on disability. The family does not respond to the request. On May 23rd after the 307 request period has expired, a 309, Second Request for Information, is issued. The family subsequently provides the required information. CHIP benefits remain open while the eligibility determination process continues.

On August 10th, the child is determined eligible in the Disabled Child Living at Home program. Her CHIP eligibility is terminated effective August 31st and ABD Medicaid eligibility is authorized effective September 1st in the system.

101.16.09 SSI REVIEWS REQUIRED FOR SSI TERMINATIONS

The SSI review process is a type of exparte review. When individuals are terminated from SSI due to income and/or resources, they are systematically issued an SSI Termination Notice and an SSI Review Form, DOM-300B, upon receipt of SDX notification of termination. This form is to be completed and returned to the appropriate regional office if the recipient wants to apply for continued Medicaid coverage and is eligible under one of the coverage groups described in the SSI Termination Notice. A signed form is required. The form may be complete or incomplete. If incomplete, the specialist will take the necessary steps to obtain needed information.

NOTE: The SSI Termination Notice advises the individual to complete and return the form to the regional office with 10-days from receipt of the notice; however, allow the form to be returned prior to the date of the SSI closure. SSI/Medicaid closures are effective for the end of current month only if the SSI transaction to close SSI/Medicaid is received by the 10th day of the month; otherwise, the closure is effective at the end of the following month. If the DOM-300B is not received timely, the individual can apply at any time using the full ABD application form.

An in–person interview is not conducted, even if the program is one that normally requires an interview. However, all necessary factors of eligibility must be verified, such as disability, residency, utilization of benefits, etc. In addition, if other health insurance coverage is indicated on the 300B, TPL information must also be obtained.

SSI redeterminations have a 30-day processing standard, unless a DDS determination must be obtained.

101.16.10 RECEIPT OF REGULAR REVIEW FORMS

MAGI-related and ABD regular reviews may be submitted to a regional office is any of the means allowed for filing an application. Receipt of a redetermination or review form includes pre-populated forms that were issued by the system or manually, SSI review forms, and ABD review forms issued systematically or manually. These forms may be received in any of the following ways:

By mail in any regional office or in the central office.	If received in the incorrect RO, forward to the correct RO in the same manner as an application.
By fax or a scanned version received by e-mail.	An original signature is not required.
In-person in any regional office, out-stationed site or other location where eligibility staff are on official duty.	If assistance is requested in completing the renewal form, assistance must be provided on the day the individual comes into the office or other location.
By telephone. Assistance completing the review form must be offered if needed.	Unless the telephone review is recorded, the review form must be mailed to the individual to sign and return to the agency.

Review forms are not offered on-line and cannot be completed and returned to the agency on-line.

101.16.11 DISPOSITION OF A REGULAR REVIEW – ABD AND MAGI

ABD and MAGI redeterminations are completed administratively, if possible, or by use of a pre-populated review form that is issued either systematically or manually, as discussed above. When the form is returned and all information subject to change has been evaluated and a decision is reached regarding continuing eligibility, the following actions will be authorized:

101.16.11A APPROVAL OF A REGULAR REVIEW

When the ABD recipient/representative or MAGI head of household has complied with all redetermination requirements and provides required verifications, the specialist will review the eligibility criteria; ensure appropriate documentation is filed in the case record and input the data into the system for an eligibility decision. All redeterminations are submitted for supervisory review and authorization. When eligibility will continue at the same level, a new review due date is established and an approval notice issued to the recipient or head of household when benefits are authorized.

101.16.11B REDUCTION OR TERMINATION OF BENEFITS

Advance notice of adverse action is required, if the eligibility decision results in termination of benefits for all or some members of the case. During the adverse action period, the recipient or head of household is allowed time to fully comply with unmet redetermination requirements, provide information or verification that will alter the adverse action decision or request a fair hearing with continued benefits.

For MAGI-related cases, adverse action is required to terminate benefits for one or all members of the household.

For ABD cases, adverse action is required in all of the following situations:

- Termination of benefits;
- Conversion to a reduced services coverage group;
- Termination of a nursing facility per diem payment.

101.16.11B REDUCTION OR TERMINATION OF BENEFITS (Continued)

The system is not programmed for the case to remain open during the adverse action period; however, eligibility staff must treat the case as if it is open until the period has ended. During this period if the ABD recipient or MAGI head of household subsequently complies with all redetermination requirements or provides information which changes the negative action, eligibility must be reinstated. If the client requests a hearing, with continued benefits, the case must be promptly reinstated.

Specialists must take prompt action on the information provided during the advance notice period. Timely action must be taken to prevent a break in coverage, whether the client takes action within the first few days of the adverse action period or on the final day.

ABD Example: The recipient did not provide income verification needed for the May redetermination. The closure is authorized on May 10th and advance notice is mailed to the recipient advising that eligibility will terminate effective May 31st. On May 18th, within the advance notice period, the verification is received in the office. The specialist takes action to process the case as a reinstatement and determines eligibility using the current income. The supervisor then reviews the action and authorizes the eligibility decision. Appropriate notice is issued to the client and there is no break in coverage.

MAGI Example: The head of household failed to comply with redetermination requirements for a May redetermination. The case was closed on May 15th effective May 31st. On May 29th partial verification is provided; however, all information needed to process the case is not provided. A reinstatement contact is registered for May 29th. A 307 is issued for the information and 30-day processing is applicable.

101.16.12 REQUESTED INFORMATION PROVIDED AFTER CLOSURE

When an ABD or MAGI case is closed due to failure to provide information, a reapplication is not required if the following are met:

- The recipient or head of household subsequently provides all information necessary to complete the redetermination; **and**

- The case has been closed for 90-days or less at the time the information is provided.

  Example: The recipient did not provide income verification needed for the May redetermination. The closure is authorized on May 10th effective May 31st. If the information is furnished by August 31st, eligibility can be determined using the reinstatement process. After August 31st, a reapplication must be filed.

NOTE: If a MAGI-related child was not due for review when action was taken to terminate other household members who were due for review, the 90-day provision described above does not apply since any child(ren) not due for review could not have been closed with a future date. Children undergo a full review at the time end of their 12-month protected period.

The specialist is responsible for taking action within 48 hours of receipt of the information to register the reinstatement in the system. The case will be processed based on the most recent application and/or renewal form. There is no requirement to obtain an updated signature on the application form. Refer to the Reinstatement policy for a complete discussion of the process required to reinstate eligibility.