

Implementation Guide: Medicaid State Plan Eligibility General Eligibility Requirements Eligibility Process

Contents

POLICY CITATION.....	2
BACKGROUND.....	2
Overview	2
Application	2
Renewal	2
Notices	4
INSTRUCTIONS	4
A. Submission of Application.....	4
B. Establishment of Outstation Locations	5
C. MAGI Renewals	5
D. Renewals on a Basis Other than MAGI.....	5
E. Determination of Ineligibility	6
F. Assistance with Application and Renewal.....	6
G. Notices	6
H. Authorized Representatives	7
I. Coordination of Eligibility and Enrollment	7
J. Additional Information (optional).....	7
REVIEW CRITERIA.....	7

Eligibility Process

POLICY CITATION

Regulation: 42 CFR 435.10
42 CFR 435, Subpart J and Subpart M

BACKGROUND

Overview

This reviewable unit (RU) describes the processes used by individuals to apply for and renew Medicaid eligibility, as described at 42 CFR 435 subpart J. This includes policies and options about how applications may be submitted, the frequency and methods used for renewal of eligibility, requirements when determining ineligibility, assistance with application and renewal, notice requirements, and the use of authorized representatives. Also described in this RU is the coordination of eligibility and enrollment between Medicaid and other insurance affordability programs (Children's Health Insurance Program, Basic Health Program, and Marketplace).

Application

Consistent with 42 CFR 435.907, states must accept an application from:

- An individual applying for coverage,
- An adult who is in the applicant's household,
- An authorized representative, or
- If the applicant is a minor or incapacitated, someone acting responsibly on behalf of the applicant.

All applicants must have the opportunity to apply online, by telephone, through the mail or in person. This requirement applies to applications for Medicaid eligibility based on modified adjusted gross income (MAGI) and on a non-MAGI basis. States must also provide pregnant women and children with an opportunity to apply for Medicaid at other outstation locations.

Option: Other Electronic Means. States have the option to accept applications by electronic means other than those described above. When this option is elected, the state must describe the additional electronic processes in the **Eligibility Process** RU.

Renewal

Beneficiaries whose financial eligibility is based on MAGI must have their eligibility renewed once (and only once) every 12 months, unless the agency receives information about a change that may affect eligibility. For individuals who are eligible on a non-MAGI basis, eligibility must be renewed at least once every 12 months.

Option: Non-MAGI Renewal Frequency. States may elect to renew eligibility for non-MAGI beneficiaries more frequently than once every 12 months. States also have the

option to establish different renewal periods for different populations of non-MAGI beneficiaries.

When renewing eligibility for any individual (both MAGI and MAGI-excepted), states must attempt to complete the renewal based on current information available to the agency, in accordance with 42 CFR 435.916(a)(2). If available information indicates no change or a change that still results in Medicaid eligibility, the agency must renew without requiring further action from the beneficiary.

If eligibility cannot be renewed solely on the basis of information available to the agency, 42 CFR 435.916(a)(3) requires the following steps for beneficiaries whose financial eligibility is based on MAGI.

- The state must provide a renewal form pre-populated with information already known to the agency and provide for a reasonable period of time for the beneficiary to respond and provide any additional information needed.
- Beneficiaries must be given a minimum of 30 days from the date of the renewal form to provide necessary information.
Option: Additional Information. States have the option to extend the timeframe for beneficiaries to provide additional information. The chosen timeframe must be described in this RU.
- A beneficiary may submit the renewal form online, in the mail, by telephone, or in person.
- When a beneficiary does not respond within the required timeframe, the agency appropriately terminates coverage with all available consumer protections. If the beneficiary subsequently submits the renewal form within 90 days after coverage is terminated, the agency must determine eligibility without requiring a new application.
Option: Reconsideration of Eligibility. States have the option to extend the 90 day reconsideration period for beneficiaries to submit a renewal form. The chosen time period must be documented in this RU.

For individuals whose financial eligibility is not based on MAGI, 42 CFR 435.916(b) provides states with additional flexibility.

- States may elect to use a similar process for both MAGI-based and non-MAGI renewals or they may choose to use an alternative process for some or all non-MAGI renewals.
- If a similar process is used, the state may:
 - Utilize either a pre-populated renewal form or a standardized renewal form,
 - Allow for submission of the renewal form through specific methods, and
 - Reconsider eligibility without requiring a new application, if an individual submits the renewal form within a specified timeframe after eligibility is terminated for failure to complete the renewal process.
- If an alternative process is used, the state must describe the process in the **Eligibility Process** RU.

- States may apply different processes for different types of renewals, but any differences must be clearly identified in the **Eligibility Process** RU.

Notices

As described in 42 CFR 435.917, states must provide applicants and beneficiaries with timely and accurate notice of any decision that would impact the individual's eligibility or coverage. This includes approval, denial, termination, or suspension of eligibility and a denial or change in benefits or services. Such notices must be written in plain language and be accessible to persons who are limited in English proficiency and individuals with disabilities. In this RU, states describe how they achieve this objective.

When the state completes a determination of eligibility, the individual must be provided with a notice that includes:

- The basis and effective date of eligibility,
- Circumstances that may affect eligibility and procedures for reporting a change in circumstances,
- Medical expenses that must be incurred to establish eligibility (if applicable),
- Basic information on the level of benefits and services,
- Premiums and cost sharing obligations (if applicable), and
- Explanation of the right to appeal the eligibility determination or covered benefits.

New applicants who are determined ineligible must be provided with a notice that includes the basis for the determination and an explanation of the right to appeal the determination. With respect to current beneficiaries, before the state may take any adverse action, including actions to terminate, discontinue or suspend an individual's eligibility and actions to reduce or discontinue services and benefits, the state must send notification of the action at least 10 days prior to the effective date as described in 42 CFR 431.211.

Individuals may elect to receive notices in an electronic format or by regular mail, as described at 42 CFR 435.918, and they may change this election at any time. For those who do not reside in a permanent dwelling or have a fixed mailing address, states must ensure that notices, as well as cards evidencing eligibility for medical assistance, are made available to the individual.

INSTRUCTIONS

A. Submission of Application

- At **A.1.**, indicate that procedures permit an individual or authorized person to submit an application via the internet, by telephone, via mail or in person and that these methods are available to all such persons regardless of the eligibility methodology that applies. To do this, check the box next to the assurance.
- At **A.2.** select **Yes** or **No** to indicate if the Medicaid agency also accepts applications by other electronic means.
 - If **Yes**, select the **Add Electronic Means** button.

- Enter the name of the electronic means and a description in the text boxes that are provided and select the *Save* button.
- If there is more than one other electronic means to accept applications, select the *Add Electronic Means* button again to add the additional electronic means.
- To delete an *Electronic Means*, select the *X* in the Delete column next to the electronic means you wish to delete.
- At **A.3.** indicate that any application or supplemental form is accessible to persons with limited English proficiency and persons with disabilities. To do this, check the box next to the assurance.

B. Establishment of Outstation Locations

Indicate that there are procedures to take applications, assist applicants and perform initial processing of applications, for the eligibility groups listed at **B.1.** through **B.3.**, at locations other than those used for receipt and processing of title IV-A applications, including Federally-qualified health centers and disproportionate share hospitals. To do this, check the box next to the assurance.

C. MAGI Renewals

- Indicate that redeterminations of eligibility for individuals whose financial eligibility is based on MAGI are performed consistent with the cited regulatory requirements and the statements listed at **C.1.** through **C.4.** To do this, check the box next to the assurance.
- At **C.4.b.**, select one of the two options (**C.4.b.i.** or **C.4.b.ii.**) to indicate the number of days from the date of the pre-populated renewal form that recipients have to respond and provide any necessary information.
 - If **C.4.b.ii.** is selected, indicate the number of days in the text box provided.
Screen Validation: The number entered must be greater than 30.
- At **C.4.e.**, indicate the number of days an individual has to submit the renewal form after the termination date, by selecting one of the two options at **C.4.e.i.** and **C.4.e.ii.**
 - If **C.4.e.ii.** is selected, indicate the number of days in the text box that is provided.
Screen Validation: The number entered must be greater than 90.

D. Renewals on a Basis Other than MAGI

- Indicate that redeterminations of eligibility for individuals whose financial eligibility is not based on MAGI are performed as indicated in the remainder of this section and consistent with the cited regulation. To do this, check the box next to the assurance.
- At **D.1.**, indicate the frequency of these redeterminations by selecting one or more of the options at **D.1.a.** through **D.1.c.** You may have more than one frequency because you may vary the frequency by population.
 - If **D.1.c.** is selected, indicate the frequency by entering it in the text box that is provided.

Screen validation: The number edited must be greater than zero and cannot exceed 11.

- At **D.3.**, select one or both of the options to describe the process used if eligibility cannot be determined solely on the basis of available information.
 - If **D.3.a.** is selected:
 - At **D.3.a.i.**, select *Yes* or *No* to indicate that the renewal form is pre-populated with information available to the agency.
 - At **D.3.a.ii.(1)**, select one of the two options to indicate the number of days the individual has from the date of the renewal form to respond and provide necessary information.
 - If **D.3.a.ii.(1)(b)** is selected, enter the number of days in the text box provided.

Screen validation: The number entered must be greater than 30.
 - At **D.3.a.ii.(2)**, select one or more of the options to indicate the methods that may be used to submit a renewal form.
 - If **D.3.a.ii.(2)(e)** is selected, describe the other means in the text box provided.
 - At **D.3.a.ii.(4)** select *Yes* or *No* to indicate whether the state reconsiders eligibility without a new application if the individual submits the renewal form within a certain time period after the termination date.
 - If *Yes*, select one of the two options to indicate the number of days the individual has to submit the renewal form in this circumstance.
 - If **D.3.ii.(4)(b)** is selected, enter the number of days in the text box provided.
 - If **D.3.b.** is selected, describe the alternative process used to redetermine eligibility in the text box provided.
 - If both **D.3.a.** and **D.3.b.** are selected, at **D.3.c.**, provide an explanation for the selection of both processes.

E. Determination of Ineligibility

Indicate that the state complies with the actions required prior to making a determination of ineligibility. To do this, check the box next to each assurance.

F. Assistance with Application and Renewal

Indicate that the agency provides assistance to any individual seeking help with the application or renewal process. To do this, check the box next to the assurance.

G. Notices

Indicate that the state complies with the listed notice requirements. To do this, check the box next each of the five assurances.

- At **G.3.** provide an explanation of the method used to make notices and cards available to individuals without a permanent dwelling in the text box provided.

- At **G.5.** select one or more of the three options presented to indicate how the state ensures that notices are clear and understandable by the consumer.
 - If **G.5.c.** is selected, provide a description of the other method used in the text box provided.

H. Authorized Representatives

Indicate that the state complies with requirements pertaining to authorized representatives. To do this, check the box next each of the three assurances.

I. Coordination of Eligibility and Enrollment

Indicate that the state complies with requirements for coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. To do this, check the box next to the assurance.

J. Additional Information (optional)

Except in limited circumstances, this field remains blank. Please consult with CMS before adding any additional information concerning this RU.

REVIEW CRITERIA

If the state checks Yes at A.2., it must enter the name and a description of the other electronic means in the spaces provided. The description needs to be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements.

If Other is selected at D.3.a.ii.(2)(e), the description of the other method used to submit a renewal form must be sufficiently clear so that the reviewer can understand the method being used and determine whether it complies with Medicaid requirements.

If D.3.b. is selected, the description of the alternative process to redetermine eligibility must be sufficiently clear so that the reviewer can understand the alternative process and determine that whether it complies with Medicaid requirements.

If D.3.c. is selected, the explanation of how the alternative process to redetermine eligibility described at D.3.b. interacts with the process at D.3.a. must be sufficiently clear so that the reviewer can understand how the two processes work together and determine whether they comply with Medicaid requirements.

The description of the methods used to make notices and cards available at G.3. must be sufficiently clear so that the reviewer can understand the process and determine whether it complies with Medicaid requirements.

The description of the method used to assure that notices are clear and understandable at G.5.c. must be sufficiently clear so that the reviewer can understand the process and determine that whether it complies with Medicaid requirements.