2205.15.00 REDETERMINATIONS (ANNUAL RENEWAL) BY MAILER

For both MAGI and non-MAGI cases, the agency makes a redetermination of eligibility without requiring information from the individual when possible. The redetermination is based on reliable information contained in the individual's account or other more current information available to the agency (such as data from The Work Number or the Asset Verification System). (see 2205.00.00),

If the agency is unable to automatically redetermine the eligibility of the individual, then an Eligibility Review Form (redetermination mailer) is sent.

Renewal Forms

When an individual cannot qualify for ex-parte (automatic) renewal, they will be sent a prepopulated mailer which tells them what information we currently have for them, asks them to tell us of any changes, and requires verification of noted eligibility factors subject to change. If more than one member of a Medicaid assistance group is due for renewal, a combined form will be sent. The form will include a due date of 30 days from the mailing date.

Note: If one member of the household qualified for ex-parte renewal and one member is required to complete the form, and the form is not returned, there will be no negative eligibility impact to individual who was ex-parte renewed.

Renewal forms may be completed by any of the following methods:

- By completing and signing the form by hand and mailing, faxing, or taking the form and any other required documentation to the DFR
- By completing and signing the form by hand and uploading the form and any other required documents to the member's online Benefits Portal account
- By answering the online renewal questions, uploading required documents, and electronically signing in the member's online Benefits Portal account
- At the member's request, a renewal interview can be completed over the phone and their signature recorded. If a Medicaid member requests an office or phone interview, one must be granted, however **interviews cannot be required for renewals for any member.** If the member has an interview scheduled and does not keep the appointment, this should not cause a closure. They may still return the form and keep their coverage if they remain eligible.

The non-asset version is used when all assistance groups in a case are Hoosier Healthwise or HIP members that have no asset or resource requirements. The mailer includes a cover page with information about the process and instructions for returning the form.

The asset version is used when one or more of the AGs in a case have an asset or resource requirement. For example, if the members in a case are MA 2 and MA D, the asset version of the form is mailed. The mailer includes a cover page with information about the process and special

circumstances involving asset disclosure, as well as instructions for returning the form. Individuals will be evaluated based only on eligibility factors which apply to their type of coverage. Using the prior example, if the form is returned with all needed information except asset verifications and is signed, the MAGI individual would be renewed (if still eligible), a 2032 should be sent for the non-MAGI member. If 2032 is not returned, then only the non-MAGI individual would be closed for failure to verify needed information. ~~and only the non-MAGI individual would be closed for failure to verify needed information.~~

The Eligibility Review Form is sent to the adult AG payee or parent/caretaker of a child AG. If a child is the only case member and there is no authorized representative, the form is sent to the child. A Notice of Redetermination (NOR) is sent to the other adult AG payees and authorized representatives listed as "ongoing" in the case informing them that the Eligibility Review Form has been sent. The NOR identifies the recipients who are being reviewed and the due date listed on the Eligibility Review Form.

- If the individual did not sign the form or more clarification is needed on the information they provided, the DFR should contact the member to request what is needed to complete the renewal process and if written verifications are required, allow 13 days for the missing information to be returned before discontinuing coverage.
- If the member fails to respond ~~to the mailer~~ with required information and a signature, their coverage will be discontinued.
- A 90-day reconsideration period applies to annual renewals where coverage is closed for failing to return required information by the due date; for more information see 2238.25.00.
- Individuals who complied with the renewal process but were found ineligible will have their information transferred to the Federal Marketplace on the night that closure action is taken on the case. These individuals are eligible to apply on the Marketplace even outside of the typical annual open enrollment period.
- ~~If the individual did not sign the form or more clarification is needed on the information they provided, the DFR should contact the member to request what is needed to complete the renewal process.~~