STATE OF DELAWARE

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE
POLICY & PLANNING UNIT

ADMINISTRATIVE NOTICE A-08-2023

TO: DMMA and DSS Staff

DATE: May 12, 2023

PROGRAM(S): Medicaid Programs

SUBJECT: Resumption of Renewals

NOTE: This update replaces Admin. Notice DMMA-A-06-2021.

BACKGROUND

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constituted a national emergency. As a result, states were given certain flexibilities related to Medicaid eligibility determinations and renewals.

Additionally, on March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Responses Act (FFCRA) which called for states to comply with certain Maintenance of Effort (MOE) requirements, including continuous coverage requirements.

On December 29, 2022, the Consolidated Appropriations Act, 2023 (CAA, 2023) uncoupled the resumption of Medicaid renewals at the end of the COVID-19 Public Health Emergency (PHE) effective March 31, 2023. In response to the CAA, the Centers for Medicare & Medicaid Services (CMS) announced states would have 12 months to initiate renewals and a total of 14 months to complete renewals during the unwinding period. During the unwinding period states must initiate renewals for all members enrolled in Medicaid and CHIP.

DISCUSSION

In compliance with the CAA, Delaware Medicaid has elected to restart renewals on April 1, 2023. In preparation for renewals, Delaware Medicaid encouraged members to update their contact information (name, mailing address, phone number, and email address). Delaware Medicaid continues to make ongoing efforts to inform members, staff, and

community partners of the resumption of renewals by texts, emails, newsletters, Division of Medicaid & Medical Assistance (DMMA) website, ASSIST and Delaware Medical Assistance Programs (DMAP) website banners, Delaware Health and Social Services (DHSS) social media posts, flyers, and post cards.

Alignment of Renewal Application Forms During the Unwinding Period:

Each month during the unwinding period, Delaware Medicaid will initiate renewals for a maximum of 1/9th of the total household caseload. All renewals are expected to be completed by May 31, 2024. Medicaid renewals will be aligned with upcoming recertifications for the Supplemental Nutrition Assistance Program (SNAP) and other Medicaid programs, as applicable. The Renewal Distribution Plan detailed below will apply to assistance groups within the same household:

1. Align deferred Medicaid renewals with upcoming SNAP recertifications.
2. Align deferred Medicaid renewals with upcoming Medicaid renewals.
3. Align upcoming Medicaid renewals with upcoming SNAP recertifications if the SNAP recertification date is after the Medicaid renewal date.
4. Align upcoming Medicaid renewals with each other (to avoid the truncation of Medicaid eligibility periods, the dates will be synced to the latest date).

Consolidated Appropriations Act (CAA) Compliance:

Passive Renewals:

Delaware Medicaid will attempt to redetermine Medicaid eligibility for applicable programs based on reliable information in the member's case and other current information available to the agency accessed through electronic data sources. The passive renewal reasonable compatibility check percentage was increased from 10% to 25% so that a greater number of renewals can be completed passively. DHSS will notify the member of the eligibility determination, basis for the determination, and the member's responsibility to inform DHSS if the information contained in the notice is inaccurate.

Standard Renewal Application Forms:

If a passive renewal cannot be successfully completed, a pre-populated renewal application form will be mailed to the member requesting updated information. Members will receive a minimum of 30 days to return the completed renewal application form and verifications. Individuals will not be required to provide additional information or documentation unless the information cannot be obtained through electronic data sources (refer to Delaware Social Services Manual (DSSM) 14800 Verifications of Factors of Eligibility). Members can return their completed renewal application form and any verifications via in office, United States Postal Service (USPS) mail, ASSIST Self Service, fax, phone, and email. In April 2021, ASSIST Self Service was enhanced to allow members to upload verification documents. This feature is available on both "My account" and the verification screen during application and renewal processes.

Determination of Eligibility:

Members whose Medicaid was not closed due to the COVID-19 PHE continuous enrollment requirement, must go through the renewal process to determine if the member remains eligible for benefits. Delaware Medicaid will consider all categories of eligibility prior to terminating a member's benefits, as described in DSSM 14100.5 Determination of Eligibility. Refer to Administrative Notice: DMMA 06-2018 Screening for Non-MAGI Medicaid Eligibility.

Notice of Determination and Fair Hearing Rights:

A minimum of 10 days advance notice and fair hearing rights will be provided to members prior to any adverse action and/or termination.

4-Month Reconsideration Period:

Delaware Medicaid will reconsider eligibility without requiring a new application for any member whose coverage is terminated for failure to return their renewal application form or mandatory information, as long as the individual's renewal application form or requested information is returned within four months after coverage is terminated. Refer to DSSM 14100.6 Annual Renewal of Eligibility.

Example:

A renewal application form was mailed to a member on 4/12/2023 whose eligibility review date was 5/31/2023. The member did not return the renewal application form by 5/31/2023, therefore the member was automatically granted a 1-month extension (explained below). The member failed to return their renewal application form following the 1-month extension resulting in the member's Medicaid being closed on 06/30/2023 for failure to recertify. The four-month reconsideration period begins 7/1/2023 and ends 10/31/2023. Eventually the member submitted a completed renewal application form on 9/15/2023 and did not need to submit a new application. The worker processed the renewal application form on 9/15/2023 and determined that the member was eligible. The member's Medicaid was reopened without a gap in coverage effective 7/1/2023.

Other Insurance Affordability Programs:

If a member returns a completed renewal application form and is determined ineligible, Medicaid will be terminated. In these situations, Delaware Medicaid will provide information about affordable, quality healthcare options. A letter will be sent to inform terminated members about the Federally Facilitated Marketplace (FFM), Delaware 211, Delaware Medicare Assistance Bureau, Choose Health Delaware, and navigator assistance available through Quality Insights and Westside Family Healthcare.

Organization Name:	Telephone Number:	Website Address:
Choose Health Delaware		https://www.choosehealthde.com
Quality Insights	Statewide: 1-844-238-1189	https://www.qualityinsights.org/navigator
Westside Family Healthcare	New Castle County: 1-302-472-8655 Kent/Sussex: 1-302-678-2205	https://www.westsidehealth.org/marketplace
Delaware 211 (United Way)	Call 211 or toll-free 1-800-560-3372	https://delaware211.org
Delaware Medicare Assistance Bureau (DMAB)	1-800-336-9500 or 1-302-674-7364	https://insurance.delaware.gov/divisions/dmab

Extending Member Response Times:

Delaware Medicaid has elected to grant a 1-month extension of benefits to members who meet the criteria below. ASSIST Worker Web (AWW) has been updated so that Medicaid assistance groups that have not yet had a review performed will not close for failure to recertify in the month the renewal application form is due. The following Delaware Medicaid members will have an additional month to return renewal application forms:

- Members whose renewal application form was returned by the USPS.

  (Delaware Medicaid must make a good faith effort to contact the member. Alternative efforts may include, but are not limited to forwarding address, telephone number, email address, and text messaging.)
- Members who returned a renewal application form and additional information is required.
- Members who did not return their renewal application form within the first 30 days.

Questions & Answers:

Please note the following examples do not represent all possible case scenarios that may occur and are meant to be a guidance resource only.

***Question 1**- What do I do if a member failed to return their renewal application form and mandatory verification?*

Answer 1- The member is automatically given an additional 1-month extension to submit the completed renewal application form and/or the required information.

***Question 2**- We received a food benefits/SNAP renewal application form for a member who is open with Medicaid benefits. We confirmed the food benefits. Will*

we need to send out a separate Medicaid renewal application form or leave Medicaid unconfirmed until a full Medicaid renewal application form is sent out by AWW?

Answer 2- If the Medicaid benefits are continuing, staff must confirm the benefits. If the Medicaid is closing or cascading to a Medicaid assistance group with less benefits, then benefits must remain unconfirmed and open until the Medicaid renewal application form is sent out by AWW and completed.

ACTION REQUIRED

- Staff should continue to follow the policy in the Delaware Social Services Manual (DSSM) under the following sections:
  - DSSM 14100 General Application Information
  - DSSM 14100.5 Determination of Eligibility
  - DSSM 14100.6 Annual Renewal of Eligibility
  - DSSM 14100.82 Evaluation of Eligibility for Other Insurance Affordability Programs
  - DSSM 14800 Verifications of Factors of Eligibility

- Staff **must not** update the "Failed to Return a Renewal" field on the Additional Individual Demographics Details screen. Members must be given a 1-month extension if they failed to return their renewal application form and/or mandatory verifications. AWW has been updated so that Medicaid assistance groups that have not yet had a review performed will not close for failure to recertify in the month the renewal application form is due**.**

- As part of redetermining eligibility for members, **staff must** cascade members between Medicaid eligibility groups to include Delaware Healthy Children's Program (DHCP) and Medicare Savings Programs (Qualified Medicare Beneficiaries-QMB, Specified Low-Income Medicare Beneficiaries-SLMB and Qualifying Individuals-QI-1).

- **The FFCRA Returned Mail Conditions**

  Whenever the member's renewal application form is returned by the USPS, Delaware Medicaid must make a good faith effort to contact the member using at least two modalities, if available. Delaware Medicaid will compare the address to the one in the case record for accuracy and completeness. If the address was incomplete such as missing an apartment number, staff must correct the address, document the change in case comments, and resend the renewal application form to the corrected address. If after sending the renewal application form to the member a second time, the mail is not returned, staff must document this in the member's case record and no further action is required. Note: All address updates and modalities used must be documented in the member's case record.

- **Returned Mail with No Forwarding Address**:

  Review contact information in the member's case record to confirm the address. Staff must attempt to contact members through at least two modalities when returned mail is received from the USPS with no forwarding address to obtain the new address. Modalities include telephone, text, and/or email. If staff obtain a new address, then they must send the renewal application form to the newly identified address. If only one modality is available, staff must use it for compliance with the returned mail condition. If there is no member information available, Delaware Medicaid will be compliant.

- **Returned Mail with a Forwarding Address**:

  Staff must attempt to contact members using at least two modalities when returned mail is received from the USPS with an in-state or out-of-state forwarding address. The first modality is mail; staff will resend the returned mail to the forwarding address. The other modalities can include telephone, text, and/or email. If there is no other contact information available, Delaware Medicaid will be compliant.

- **Returned Mail with no Forwarding Address and no other Contact Information**:

  Delaware Medicaid encourages members to update their contact information and must attempt to contact members using at least two methods whenever a member's renewal application form is returned by the USPS. If the member has no other contact information other than the address listed in the record, staff are required to document this in the member's case record and Delaware will be considered compliant.

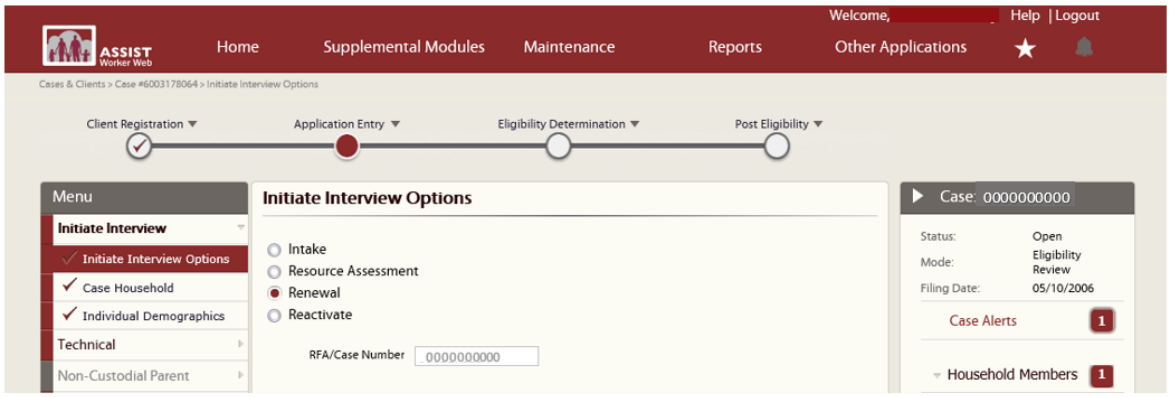
- **Refer to your Division's operational procedure for returned mail processes that are specific for the FFCRA returned mail conditions.**

  In all cases, when other forms of communication are used to attempt to contact the member, the form of communication used and date of the attempt to contact the member must be documented in the case record. A minimum of two modalities must be attempted to reach the member if there are at least two other forms of contact in the member's case.

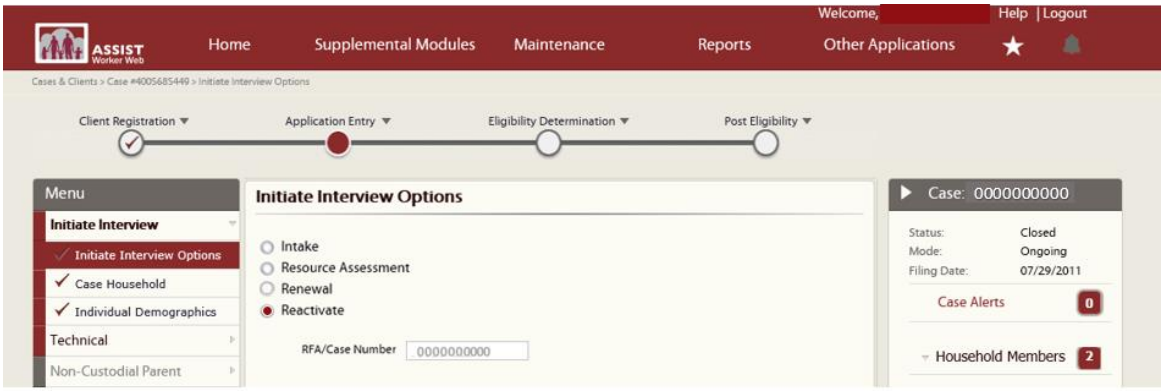
- **<u>Case Processing Requirements</u>**

  For detailed procedures regarding case processing, please refer to your Division's operational procedures and training resources.

  - Renewal application forms that are received within the certification period must be run in AWW in Renewal mode:



  - If a member submits the completed renewal application form and mandatory verification within the four-month reconsideration period, the member's case must be run in Reactivate mode:



  - Renewal application forms that are received after the four-month reconsideration period cannot be accepted. A new application is required.

- **Use of Electronic Means Reminders:**

  Individuals can submit renewal information via email, however, in compliance with Centers for Medicare and Medicaid Services (CMS) and Department of Technology and Information (DTI) guidance as it relates to the use of state electronic transmission, staff cannot send renewal information that contains *personally identifiable information (PII)* (e.g., name, address, social security number, MCI number, other identifying number, telephone number, email address,

etc.) via email or text message. Staff are only permitted to share general information by electronic means.

- Example:

  "**Urgent Message: Returned Mail Notice – Don't Risk Losing Your Benefits and Medicaid Coverage**
  Your renewal form was sent back to us from the United States Postal Service. Your case may close, and if you have Medicaid, your coverage may end if you don't complete the renewal process. You can complete your renewal by logging into your Delaware ASSIST account. Please contact us at the Customer Relations Unit at (302) 571-4900 Option 1 for information regarding your renewal. TTY users: Call 1-855-889-4325. Español, Kreyòl ayisyen, Tiếng Việt, or other languages: Call 1-866-843-7212.

  You can also update your contact information such as name (your name and those in your household), mailing address, email address, and phone number.
  You can make updates to your contact information by:
  - Logging onto your Delaware ASSIST account.
  - Calling the Change Report Center at (302) 571-4900, Option 2
  - Sending changes via fax to (302) 571-4901."

Staff should always inform members that email communications are not secure and can be intercepted in transmission or misdirected. Staff should encourage members to consider communicating any sensitive information by telephone, fax, mail, or in person.

DIRECT INQUIRIES TO

DHSS_DMMA_PPU@delaware.gov

5/12/2023 | 3:18 PM EDT
Date

DocuSigned by:
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