STATE OF DELAWARE

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

ADMINISTRATIVE NOTICE A-09-2025

TO:	DMMA/DSS Staff
DATE:	October 3, 2025
PROGRAM(S):	Medicaid Programs: MAGI, Non-MAGI, LTC
SUBJECT:	90-Day Reconsideration Period at Renewal

BACKGROUND

Federal regulations 42 CFR 435.916(b)(2)(iii) require that when an individual's benefits are terminated for failure to complete the renewal process, the state must reconsider their eligibility if the renewal and/or verifications are received within 90 days from the date of termination. The renewal serves as an application and the state must reconsider the individual's eligibility without requiring a new application.

DISCUSSION

On January 1, 2025, under 28 DE Reg. 387, Delaware Medicaid reduced the Reconsideration Period for renewals from 120 days to 90 days. This aligns the Reconsideration Period with retroactive eligibility procedure.

The reconsideration period may not provide coverage back to the date of termination.

- For Delaware Healthy Children Program (DHCP) and Qualified Medicare Beneficiaries (QMB) programs, individuals cannot be re-opened back to the date of termination. These individuals will have a gap in coverage.

- For all other Medicaid programs, eligibility needs to be determined for each month within the retroactive period to help close the gap in coverage.

The date the renewal form and/or verification(s) are received is the filing date.

Example 1: Benefits were procedurally closed because the individual's renewal was not received. The individual submitted the renewal form within

the 90-day reconsideration period. The date the renewal form is received by the agency is the filing date, and staff must reconsider the individual's eligibility.

Example 2: The signed renewal form was received timely, but additional information was requested and not received. Benefits were procedurally closed. The individual submitted the needed verification within the 90-day reconsideration period. The date the verification is received by the agency is the filing date, and staff must reconsider the individual's eligibility.

This filing date officially ends the reconsideration period.

- The filing date begins the time standard required to make a determination of eligibility:
    1. Ninety (90) days for programs based on disability with a medical eligibility requirement. This includes Medicare for Workers with Disabilities (MWD), Children's Community Alternative Disability Program (CCADP), and Long Term Care (LTC).
    2. Forty-five (45) days for all other programs.
- If additional information is required, staff must request only the information needed to renew eligibility and allow the individual 30 days to submit the information. The time standards for application processing apply.

Operationalizing a 90-Day Reconsideration Period in ASSIST Worker Web (AWW):

Please Note: The following workaround can be used until needed changes are completed in AWW. Do not use this workaround for Delaware Healthy Children Program (DHCP), and Qualified Medicare Beneficiary (QMB), as these programs are not eligible for retroactive coverage within the reconsideration period.

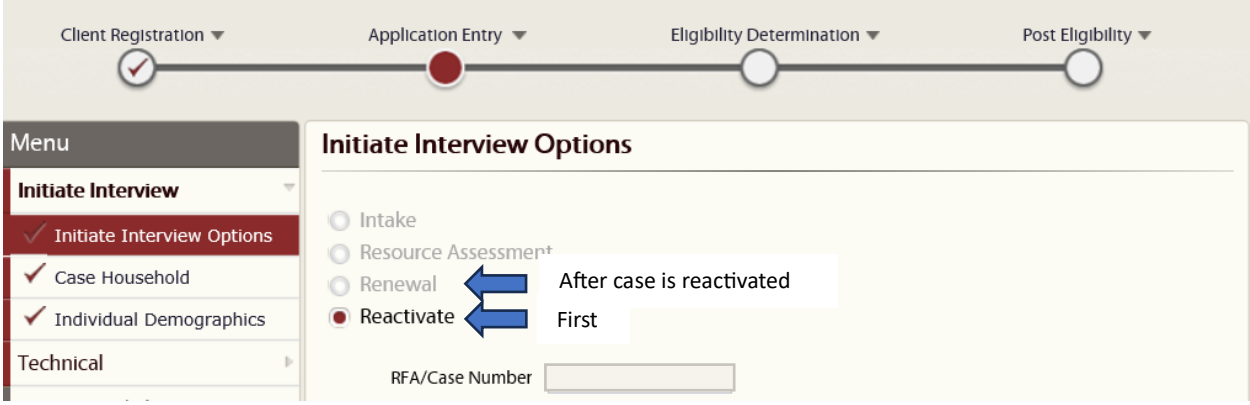
The date that the renewal or verifications is received by the agency is the date staff should use as the filing date. Adjusting the filing date accordingly will allow AWW to determine retroactive eligibility for all Medicaid programs.

Example: The individual's benefits were closed January 31, 2025, and the member submitted information on March 5, 2025. Although the filing date is technically March 5, 2025, to cover the gap in coverage, you will need to adjust the filing date to February 1, 2025. This will allow AWW to determine eligibility and build a budget beginning February 1, 2025. Remember to add the technical filing date of March 5, 2025, to the case comment.

For closed cases:
Staff will reactivate the member's case in AWW by selecting *Reactivate* on the Initiate Interview Options Screen in the Application Entry section of AWW.

Once staff have reactivated the case, staff need to go back to the Initiate Interview Screen and select Renewal to place the case in Renewal mode.

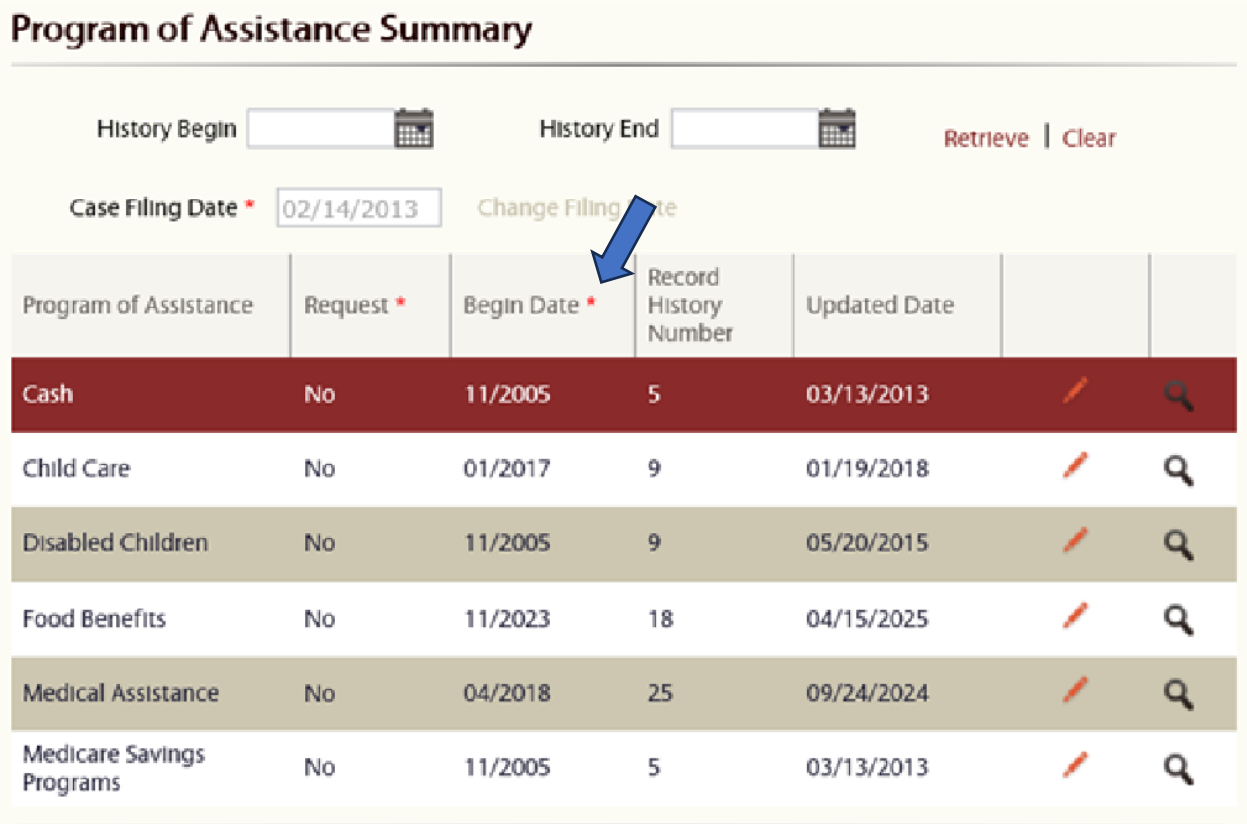
Initiate Interview Options Screen:



Cases open with other benefits start here:

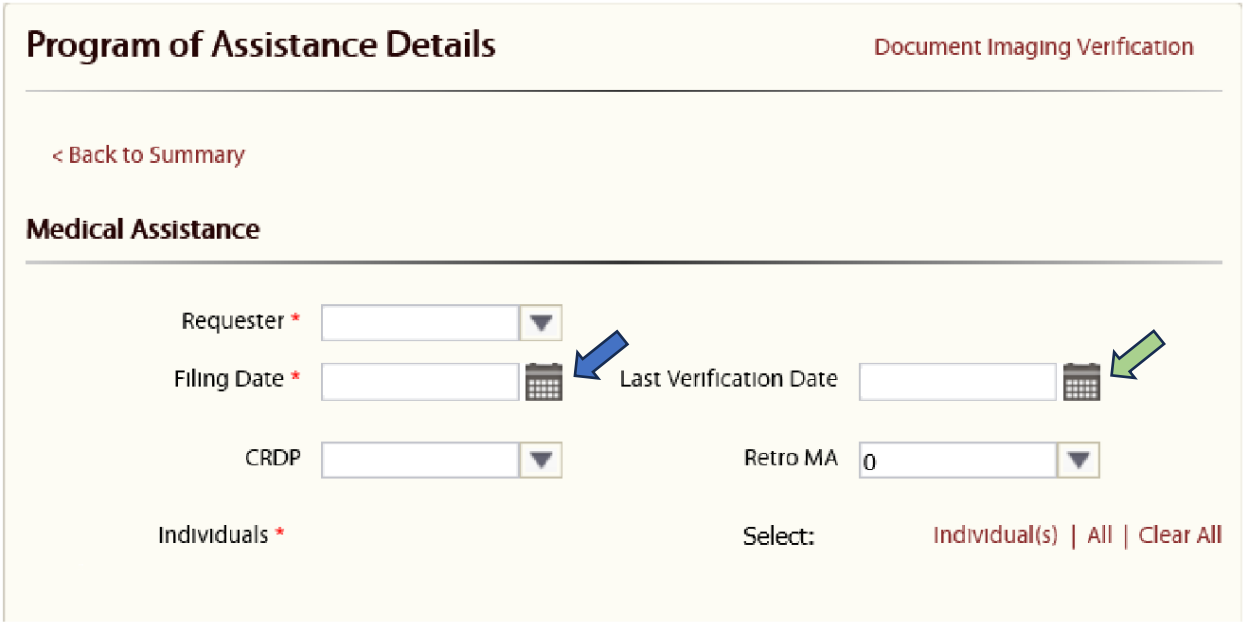
All cases: reactivated or currently open with other benefits will need to be put in Renewal Mode to process eligibility within the reconsideration period.

Staff will update, as needed, the Case Household and Individual Demographic screens.



On the Program of Assistance (POA) Summary screen, staff need to update the *Begin Date* for the appropriate Medicaid program:

- For most programs, staff should enter the first day of the month following the date that benefits were terminated.
- For Delaware Healthy Children (DHCP), and Qualified Medicare Beneficiary (QMB), staff will use the month the renewal or verification is received by the agency as the begin date.



Note: This screen will look slightly different for CCADP and the Medicare Savings Programs.

On the Program of Assistance (POA) Details screen, staff will update the following fields:

- Filing Date: This date needs to match the Begin Date used on the POA Summary screen.
- Last Verification Date: This date will be the date the renewal or verification is received.

Staff should proceed with updating the case information for the renewal and running the case for a determination.

- For a case open with other benefits, such as food benefits, staff may have to run backwards with dates for each month to determine if the individual is eligible within the gap in coverage.

Managed Care Enrollment:

Members whose cases are re-opened within the first 60 days of the reconsideration period will be automatically re-enrolled with the same Managed Care Organization (MCO).

Members whose cases are reopened after day 61 will need to re-enroll with the MCO by calling the Health Benefit Manager at (866) 996-9969. If the individual does not call to enroll with an MCO, the individual will automatically be assigned to an MCO for enrollment after 30 days of an eligibility determination. The individual may be automatically assigned to any of the MCOs. Not calling to select an MCO may delay the enrollment date.

The MCO enrollment will *not be backdated* for the reconsideration period. Services are covered under fee-for-service (FFS) until the individual is re-enrolled with an MCO.

- ***Exception for Nursing Home, Long Term Care Community Services, and Medicaid for Workers with Disabilities:***

  These programs do not have FFS in place, and are MCO capitation payment only. For clients in these programs who are re-opened during a reconsideration period, staff will need to request the MCO enrollment to be back dated to the date of eligibility.

ACTION REQUIRED

Staff ***must*** enter a case comment titled: *Reconsideration Period Determination*.
The case comments ***must*** include the following information:

- Dates: closure and when the renewal form and/or verification was received.
- If additional verification is needed. Include verification type(s).
- Date the determination is made.
- Date the member's eligibility is effective ongoing.
- Did retroactive eligibility close a gap in coverage?

  Example:
  Reconsideration Period Determination
  Closure for failure to complete the renewal process January 31, 2025.
  Renewal Form received April 15, 2025.
  Request for verification sent on April 18, 2025, requesting employment income verification.
  Information received and case run and confirmed on April 30, 2025.
  Client over income for February.
  Retroactively eligible effective March 1, 2025, ongoing.

Staff ***must*** review the following Delaware Social Services Manual (DSSM) Policies:

- DSSM 14100.6 Annual Renewal of Eligibility
- DSSM 14920 Retroactive Eligibility
- DSSM 14100.5.1 Timely Determination of Eligibility
- DSSM 20103.1.1 Time Standard

Staff ***may*** review the following Federal Regulations:

- 42 CFR 435.916(b)(2)(iii)
- 42 CFR 435.912(c)(3)

DIRECT INQUIRIES TO

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10/8/2025 | 2:47 PM EDT
Date

DocuSigned by:
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