441—76.14(249A) Reenrollment. Reviews of all conditions of eligibility will occur for the purposes of determining continued enrollment in Medicaid.

76.14(1) *Reenrollment frequency.*

a. Eligibility reviews for eligibility prior to January 1, 2014.

(1) Eligibility reviews shall be made as often as circumstances indicate, but in no instance shall the period of time between reviews exceed 12 months.

(2) Eligibility reviews will be conducted using information contained in and verification supplied with the review form specified in 441—subrule 75.52(3).

(3) When the review form is issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the fifth calendar day of the following month.

(4) When the review form is not issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

b. Eligibility reviews for eligibility effective on or after January 1, 2014.

(1) Eligibility reviews for members whose eligibility is based on the modified adjusted gross income methodology, who are eligible for Medicaid related to reciprocity for a subsidized adoption, who are eligible for Medicaid programs that are solely state-funded, who are Medicaid-eligible based upon the receipt of Medicaid related to foster care at the time they aged out of foster care, and who are eligible based on breast or cervical cancer treatment shall be conducted once every 12 months and no more frequently.

(2) Eligibility reviews for other members shall be made as often as circumstances indicate, but in no instance shall the period of time between eligibility reviews exceed 12 months.

76.14(2) *Reenrollment process.*

a. Reenrollment process prior to January 1, 2014.

(1) Within ten working days from the date a written request is issued, the member shall supply, insofar as the member is able, additional information needed to establish continued eligibility.

1. The member shall give written permission for the release of information when the member is unable to furnish information needed to reestablish eligibility.

2. Failure to supply the information or verification requested or refusal to request assistance and authorize the department to secure the requested information from other sources shall serve as a basis for cancellation of Medicaid. Signing a general authorization for release of information to the department does not meet this responsibility.

(2) Information for the eligibility review shall be submitted on Review/Recertification Eligibility Document (RRED), Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), with the following exceptions:

1. Persons whose eligibility for Medicaid is related to the family medical assistance program shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

2. Persons whose eligibility for Medicaid is related to supplemental security income and who are receiving state supplementary assistance shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

3. Persons whose eligibility for Medicaid is based on foster care, subsidized adoption or subsidized guardianship shall have continued eligibility determined by submission of Foster Care, Adoption and Guardianship Medicaid Review, Form 470-2914 or Form 470-2914(S).

4. Individuals whose eligibility is for the medically needy coverage group shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

(3) For SSI-related Medicaid for adults, the department may request a face-to-face or telephone interview. Failure of the member to attend a scheduled interview shall serve as a basis for cancellation of assistance for adults. Failure of the member to attend an interview shall not serve as a basis for cancellation of assistance for children.

(4) If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all questions answered and is signed, dated and accompanied by verification as required in 441—paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

(5) Reinstatement. When medical assistance has been canceled for failure to return a completed review form, assistance may be reinstated without a new application if the department receives the completed form within 14 calendar days of the effective date of cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the information.

b. Reenrollment process effective on or after January 1, 2014.

(1) Reenrollment shall be based on information contained in the member's electronic case record or other more current information available through electronic data matches. The member will be notified of the determination of continued eligibility and the basis of the determination on Notice of Action, Form 470-0485 or Form 470-0485(S). If any information contained in Form 470-0485 or Form 470-0485(S) is inaccurate, the member must sign and return the notice with accurate information within 30 days of the date on the notice.

(2) When eligibility cannot be determined based on information in the electronic case record and data matches, the member will be provided with a prepopulated renewal form and will have 30 days from the date of the renewal form to sign and return the form with necessary information.

1. Members whose eligibility is based on the modified adjusted gross income methodology shall complete and return Medicaid/HAWK-I Review, Form 470-5168, 470-5168(S), 470-5168(M), or 470-5168(MS).

2. Members whose eligibility for Medicaid is not based on the modified adjusted gross income methodology shall complete and return Medicaid Review, Form 470-3118, 470-3118(S), 470-3118(M), or 470-3118(MS) when requested to do so by the department. Members whose eligibility has been determined on the basis of age, blindness or disability must sign and return the notice within 30 days of the date on the notice and provide verification of income and resources before a determination of continued eligibility can be made.

(3) Enrollment will end when information or documentation necessary to complete the determination of continued eligibility is not returned within 30 days. The department shall notify the member on Notice of Action, Form 470-0485 or Form 470-0485(S).

(4) Reconsideration period.

1. For all coverage groups, except those specified in numbered paragraph "2" below, the eligibility of an individual who is terminated for failure to submit the applicable review form or necessary information shall be reconsidered in a timely manner and without requiring an application if the individual subsequently submits the review form within 90 days after the effective date of termination. If the ninetieth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the review form. The eligibility effective date shall go back to the first day of the first month of ineligibility only if all other eligibility criteria are met for that month. Eligibility for subsequent months within the reconsideration period can still be determined even if the applicant remains ineligible for the initial reconsideration month(s), but eligibility shall not be granted any earlier than the month in which all eligibility criteria are met.

2. For qualified Medicare beneficiaries (QMBs), the home- and community-based services (HCBS) waiver groups, and the program for all-inclusive care for the elderly (PACE), the provisions in numbered paragraph "1" above shall apply except that the form shall be acted upon and treated like an application. The eligibility effective dates shall also follow rule 441—76.13(249A) for these specified groups.

(5) An individual whose eligibility is not based on the modified adjusted gross income methodology must attend a face-to-face or telephone interview if requested to do so by the department.

[**ARC 1069C**, IAB 10/2/13, effective 10/1/13; **ARC 3353C**, IAB 10/11/17, effective 10/1/17; **ARC 3354C**, IAB 10/11/17, effective 10/1/17]