441—76.14(249A) Reenrollment. The department will review all conditions of eligibility for the purpose of determining continued enrollment in Medicaid pursuant to 441—Chapter 75.

76.14(1) *Reenrollment frequency.*

a. The department will conduct eligibility reviews for members whose eligibility is based on the MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided by rule 441—76.15(249A) and paragraph 76.14(1)*"b."*

b. The department will conduct eligibility reviews for the following coverage groups as circumstances indicate but no more frequently than once every 12 months:

(1) Transitional Medicaid as described in 441—subrule 75.3(6).

(2) Medicaid for former foster care youth (EMIYA) as described in 441—subrule 75.3(12).

(3) Postpartum Medicaid as described in 441—subrule 75.3(4).

c. The department will conduct eligibility reviews for members whose eligibility is based on non-MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided in rule 441—76.15(249A) and paragraph 76.14(1)*"b."*

76.14(2) *Reenrollment process.*

a. Reenrollment procedure. Reenrollment will be based on reliable information contained in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS. If the department is able to renew eligibility based on such information, the department must notify the individual of the eligibility determination and the basis of that determination. If any information in that notification form is inaccurate, the member must inform the department through any of the modes permitted for submission of an application under paragraph 76.2(1)*"b"* within 30 days.

b. Members whose eligibility for Medicaid is based on the MAGI methodology. If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

c. Members whose eligibility for Medicaid is in non-MAGI related coverage groups. If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

d. Failure to reenroll. Enrollment will end when information or documentation necessary to complete the determination of continued eligibility pursuant to subrules 76.8(2) through 76.8(4) is not returned before the end of the enrollment period. The department will notify the member of the disenrollment pursuant to 441—Chapter 16. Individuals whose eligibility ends must reapply unless the individual satisfies the requirements of subrule 76.12(3) or paragraph 76.14(2)*"e."*

e. Reconsideration period.

(1) For all coverage groups, except those specified in subparagraph 76.14(2)*"e"*(2), the department will reconsider the eligibility of an individual who is terminated for failure to submit the applicable review form as described in paragraph 76.14(2)*"b"* or *"c"* or for failure to provide necessary information in a timely manner and without requiring an application if the individual subsequently submits a review form within 90 days after the effective date of termination. The department will also reconsider eligibility as described in this subparagraph if the member provides an application form. If the ninetieth calendar day falls on a weekend or state holiday, the member shall have until the end of business hours on the next business day to provide the review form. The eligibility effective date will 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 will not be granted any earlier than the month in which all eligibility criteria are met.

(2) For qualified Medicare beneficiaries (QMB), the provisions in subparagraph 76.14(2)*"e"*(1) apply, except that the review form as described at lettered paragraph 76.14(2)*"b"* or *"c"* will be acted upon and

treated like an application and the eligibility effective date will be determined pursuant to subparagraph 76.13(1)*"a"*(2).

f. Interview required. An individual whose eligibility is not based on the MAGI methodology may be required to attend an interview to clarify information or to resolve conflicting information. The department will not require an in-person interview as part of the process.

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