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Title 210 - Executive Office of Health and Human Services

Chapter 40 - Medicaid Integrated Health Care Coverage

Subchapter 00 – N/A

Part 2 – Application and Renewal Process for IHCC Groups

2.1 Scope and Purpose

In September 2016, the State implemented its new integrated eligibility system (IES) which has the capacity to cross-walk with the State's health insurance marketplace, HealthsourceRI.gov (HSRI) and, through a single application process, evaluate eligibility for publicly financed health coverage and needs-based programs administered by DHS and other EOHHS agencies. This section focuses on the application and renewal processes that have been established in conjunction with the implementation of the IES.

2.2 Access Points

A. The State is committed to pursuing a "No Wrong Door" policy that offers consumers multiple application and renewal access points which all lead to the State's IES.

1. Self-Service – Persons seeking initial or continuing eligibility have the option of accessing the eligibility system on-line using a self-service portal through links on the EOHHS (eohhs.ri.gov) and DHS (dhs.ri.gov) websites or directly through HSRI (HealthSourceRI.com). There are also kiosks located in DHS field offices that provide direct access to the self-service portal. The information applicants provide on-line is entered directly into the eligibility system and processed electronically in real-time. For these reasons, the Medicaid agency encourages all new applicants to select the self-service portal option and complete and submit the application electronically whenever feasible.

2. Assisted Service – Applicants and beneficiaries may also apply on paper and submit forms via mail, fax, or e-mail or deliver in person to DHS field offices. Agency eligibility specialists are available to provide help, as are HSRI representatives and various certified assisters located at community agencies. Applications that are completed on paper are scanned into the IES agency portal.

3. Applicants may submit paper applications in-person or by U.S. mail, e-mail transmissions, and facsimile transmissions to the address specified on the application. Paper applications are available on-line, through the U.S. mail

upon written request, by telephone, or in person at any DHS field office. Information provided on the paper application is directly scanned or entered into the eligibility system through an agency portal by eligibility or LTSS specialists on the applicant's behalf.

2.3 Application and Renewal Assistance

A. The State provides application and renewal assistance through eligibility specialists in the DHS field offices and HSRI Contact Center and trained assisters, certified in accordance with 42 CFR 435.908. This assistance must be provided in a manner that is accessible to persons with disabilities and those who have limited English proficiency. Information on obtaining application/renewal assistance is available by calling 855-MYRIDHS (1-855-697-4347) as well as on-line through the DHS, HSRI and EOHHS websites using the links specified in this section. In addition, eligibility specialists and certified assisters are responsible for upholding the following rights of current and perspective Medicaid beneficiaries:

1. Eligibility and Renewal Help – Including help provided by DHS, EOHHS, and HSRI eligibility specialists and certified assisters in completing all necessary forms, obtaining and submitting required documentation, and responding to inquiries or requests for information. Assisters may provide help or act on behalf of the applicant or beneficiary in dealing with agency representatives, but are not permitted to make determinations of eligibility.

2. Translation Services – An interpreter or translator is available to assist in the application process upon request.

3. Protection of Privacy -- All information applicants provide is kept confidential unless the agency is otherwise authorized to share with other state and federal agencies for the purposes of verification and enrollment.

4. Timely Determinations – Eligibility determinations, including providing a notice of the agency's decision, must be made in accordance with the timelines indicated in § 2.4(A)(8) of this Part.

5. Appeals - The agency accepts appeals and holds hearings on actions related to eligibility decisions in accordance with Medicaid Code of Administrative Rules, Complaints and Appeals, or any successor regulation.

6. Non-discrimination – Applicants are treated in a manner that is free from discrimination on the basis of race, color, national origin, sex, gender identity or sexual orientation, age or disability.

2.4 Completing and Submitting the Application

A. In general, the process of completing and submitting an application proceeds in accordance with the following:

1. Account Creation – To initiate the application process, a person must create a login and establish an account in the eligibility system. This can be done through the self-service portal by the person alone or with the help of an eligibility specialist or certified assister.

    a. Identity proofing. The applicant must provide personally identifiable information for the purpose of creating an on-line account as a form of identify proofing during the process of applying for Medicaid. Verification of this information is automated. Documentation proving identity may be required if the automated verification process is unsuccessful. Acceptable forms of identity proof include a driver's license, school registration, voter registration card, etc. Documents may be submitted via mail, fax, on-line upload, or to a DHS Office.

    b. Account matches. Once identity is verified, account matches are conducted to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits.

2. Account Duration – An application account is open for a period of ninety (90) days. Applications may be started at any time. Once started, progress can be saved at any point and the application returned to at a later time. Incomplete applications not submitted within ninety (90) days are automatically deleted in the eligibility system.

3. Application Materials – The application materials a person seeking Medicaid coverage must have on hand may vary depending on the application processing flow:

    a. MAGI-based eligibility. As indicated in § 2.6.2 of this Part, applicants who are under sixty-five (65) are generally evaluated first for eligibility in one of the Medicaid Affordable Care Coverage (MACC) groups before being considered for the IHCC groups. The MACC group, MAGI-based application process is explained in greater detail in Medicaid Code of Administrative Rules, Application Process. This eligibility process generally requires applicants to provide information used when filing federal tax forms and/or documents commonly used for identification and income verification purposes.

    b. SSI-based eligibility. The IHCC application process builds on the MAGI review unless a person is 65 or older. In all cases, self-

attestation of income and resources begins the process. To the full extent feasible, electronic data matches are used to verify financial information. Documentation of certain information may be required, however. In addition, when using a paper application, access to certain types of materials may be necessary.

(1) Materials that may be of assistance in completing the application include, but are not limited to:

(AA) Federal tax filing status

(BB) Social Security Numbers

(CC) Birth Dates

(DD) Passport or other immigration numbers

(EE) Federal tax returns

(FF) Information about any health coverage available to you or your family, including any information you have about the health insurance your current employer offers even if you are not covered by your employer's insurance plan, Medicare and other forms of coverage

(GG) W-2 forms with salary and wage information if you work for an employer

(HH) 1099 forms, if you are self-employed.

(2) Common types of documentation that may be needed to verify income and resources include the wage and earning and tax forms noted above and:

(AA) Copies of checks or receipts for unearned or irregular income

(BB) Bank statements

(CC) Annuity/retirement fund statements for insurance companies

(DD) Copies of bonds

(EE) Stock ownership statements

(FF) Copies of life insurance policies

(GG) Statements from insurance companies or companies providing annuities

(HH) Copies of burial purchase agreements.

(3) Common documents that may be required with respect to self-employment income include:

(AA) Tax forms such as 1040 Schedule ES (Form 1040), Schedule C or comparable State form or federal return with the "Self-Employment Tax" line completed.

(BB) Business records if the applicant has not been self-employed long enough to file taxes, including financial statements, gross receipts and expenses, quarterly reports, certified statement form licensed accountant.

(CC) For royalties, honoraria, and stipends, the nature and amount of payments, any Social Security of Medicare withholding, dates of payments and frequency of payments, and/or tax forms above or 1099 MISC and the name of the issuer.

(4) Common documents that are required related to health status or disability include:

(AA) Authorization to obtain medical and/or health care records, the names and addresses of the treating physicians and other providers, health care bills incurred or paid during the three month retroactive eligibility period, or that remain unpaid from any previous period.

4. Application Filing Date – The filing date of an application is the date used to determine when eligibility begins if it is approved. The filing date is not necessarily the date an application is complete, but is typically the date a signed completed application form is submitted through the self-service portal on-line or date-stamped as received by the agency or electronic means if uploaded, mailed, faxed, or scanned or delivered in-person. The filing date may be protected if the application is not complete due to outstanding verifications or required reforms. The timeline the agency must meet for making an eligibility determination does not begin until the date an application is complete, as indicated below, however.

5. Application Completeness – An application must be complete before a determination of eligibility can be made. An application is considered complete when all information requested, including any ancillary required forms and authorizations, are date-marked as received by the State. As

the timelines for making a determination of eligibility specified in subsection (8) below begin on the date the application is complete, applicants are informed and offered the opportunity to provide any additional documentation or explanations necessary to proceed to the determination of eligibility in a timely manner. Such information is provided to applicants immediately through an electronic notification from the IES when applying on-line either through the consumer self-service portal or with the assistance of an agency representative. In cases in which an agency eligibility specialist or assister is entering information into an applicant's account or scanning a paper application, information about necessary documentation is generated immediately in the on-line account and must be made available as soon as feasible.

6. Voluntary Withdrawal – An applicant may request that an application for Medicaid health coverage be withdrawn at any time either through their secure on-line account or by submitting the request in writing via the U.S. mail or fax to the EOHHS or DHS agency representative. The Medicaid agency sends a notice to the applicant verifying the time and date of the voluntary withdrawal and indicating that the applicant may reapply at any time.

7. Self-Attestation of Application Information – All questions on the application must be answered in a truthful and accurate manner. Every applicant must attest to the truthfulness and accuracy by signing a paper application in ink or by providing an electronic signature on-line under penalty of perjury. The IES verifies the information electronically to the fullest extent feasible and must verify applicant attestations in accordance with the procedures set forth in the Medicaid Code of Administrative Rules, Application Process and Verification.

8. Privacy of Application Information – Application information must only be used to determine eligibility and the types of coverage a person is qualified to receive. Accordingly, the EOHHS, the agencies under its umbrella, and all other entities serving as its agents in the Medicaid eligibility process maintain the privacy and confidentiality of all application information and in the manner required by applicable federal and state laws and regulations.

9. Eligibility Determination Timelines – Federal and State law set specific timeliness for making determinations of Medicaid eligibility. The timelines vary in length depending on whether a clinical eligibility determination is required that necessitates a review of information from second parties (e.g., health practitioner or provider) and/or third parties (e.g., insurers). In accordance with R.I. Gen. Laws § 40-8.6(b)(2) (Public Law 16-150), the timeline for determining eligibility begins on the date a completed application, including any required forms and/or authorizations are received by the EOHHS, or its authorized eligibility agents, and ends on

the date a notice is sent to the applicant explaining the agency's decision. The EOHHS is responsible for processing applications within these time limits for IHCC group members who have not been deemed or determined eligible on the basis of participation in another federal program (e.g., SSI, DCYF Foster Child, etc.). The timelines are as follows:

MACC and IHCC Eligibility Determination Timelines	
Coverage Group	**Determination Timeline**
MACC Groups	30 Days
Community Medicaid – Elders 65 and over	30 Days
Community Medicaid – Adults with Disabilities	90 Days
Sherlock Plan	If determination of disability has been made – 30 days If determination of disability or level of care is required – 90 days
Medically Needy – Persons with Disabilities	90 Days
Medically Needy – No Disability	30 Days
LTSS	90 Days

2.5 Beneficiary Responsibilities

A. Medicaid beneficiaries must provide accurate and complete information about any eligibility factors subject to change at the time of the application and annual renewal. Accordingly:

1. Consent – At the time of the initial application or first renewal, Medicaid beneficiaries are required to provide the State with consent to retrieve and review any information not currently on record pertaining to the eligibility factors subject to change through electronic data matches conducted through the State's eligibility system. Once such consent is provided, the

Medicaid agency may retrieve and review such information when conducting all subsequent annual renewals.

2. Duty to Report – Medicaid beneficiaries are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self- reports are permitted through the eligibility system consumer self-service portal as well as in person, via fax, or mail. Failure to report in a timely manner may result in the discontinuation of Medicaid eligibility.

3. Cooperation – Medicaid members must provide any documentation that otherwise cannot be obtained related to any eligibility factors subject to change when requested by the Medicaid agency. The information must be provided within the timeframe specified by the Medicaid agency in the notice to the Medicaid member stating the basis for making the agency's request.

4. Voluntary Termination – A Medicaid beneficiary may request to be disenrolled from a Medicaid health plan or to terminate Medicaid eligibility at any time. Such requests must be made in writing and preferably two (2) weeks prior to the date of disrenrollment or the date a beneficiary seeks to end eligibility.

5. Reliable Information – Medicaid applicants and beneficiaries must sign under the penalty of perjury that all information provided at the time of application and any annual renewals thereafter is accurate and truthful.

6. Change of Service Delivery Options – Medicaid beneficiaries may change Medicaid health plans during the annual open enrollment period. Notice of the open enrollment period is provided to beneficiaries at least thirty (30) days prior to the date the period begins. Beneficiaries may also request to change service delivery options at any other time in accordance with the procedures set forth in Subchapter 10 Part 1 of this Chapter, or if MACC group eligible, Medicaid Code of Administrative Rules, RIte Care Program, Rhody Health Program, Enrollment, and RIte Share Program.

7. Alternative forms of Benefits/Assistance – Applicants and beneficiaries must, as a condition of eligibility, take any necessary steps to obtain annuities, pensions, retirement and disability benefits along with any other forms of assistance available for support and maintenance that may be identified by the agency, in writing, in accordance with Medicaid Code of Administrative Rules Cooperation Requirements. Good cause exceptions are considered when requested in writing.

2.6 Application Review Process

2.6.1 Scope and Purpose

This section provides an overview of the application review process for all IHCC groups identified in this chapter and the specific provisions that apply to Community Medicaid populations subject to eligibility determinations made by the State. As a result of programmatic changes in the State's IES required by the ACA, people are no longer required to apply for one particular category of Medicaid eligibility. Instead, to maximize access and choice, applicants are evaluated across a variety of MACC and IHCC pathways which apply different eligibility standards, requirements, and criteria. In short, the denial or termination of eligibility in one category does not preclude eligibility through another pathway. The State must consider all bases of eligibility.

2.6.2 Conversion Process

A. The conversion to the State's new application review process requires new applicants and existing beneficiaries to be treated differently during the initial stages of implementation. A "new applicant", for these purposes, is a person who is not currently receiving Medicaid health coverage in any eligibility category. The conversion process is as follows:

1. New Applicants – New applicants are evaluated first using the MAGI methodology for the MACC groups.

2. Existing Beneficiaries – At the time of renewal, current IHCC beneficiaries are evaluated using the SSI income and resource standards to ensure continuity of coverage. In the process of this evaluation, an ancillary review of the information in the beneficiary's account along with updates from all available data sources is conducted to determine whether MAGI-based eligibility in one of the MACC groups is available. This review is only conducted if the beneficiary is under age 65 or 65 and older and the parent/caretaker of a Medicaid-eligible child. Upon completing this review, a notice is sent to the beneficiary indicating if an alternative form of coverage is available.

2.6.3 General Rules

A. To the extent feasible, the person seeking initial or continuing eligibility is provided with the choice of eligibility pathways within and, in some instances, across the MACC and IHCC group categories. Again, MACC group eligibility is primarily income-based and uses the MAGI standard established in conjunction with federal health care reform. IHCC group eligibility is much more varied and, when not automatic due to participation in another federal program or special requirements, is based on both the SSI methodology and SSI-related characteristics. As there are significant distinctions between these two categories for obtaining eligibility, when choosing a pathway, the following should be taken into consideration:

1. Limits on Choice – Although the scope of primary care essential health coverage across Medicaid in the broad IHCC and MACC categories does not significantly vary, there are certain differences that may affect a person's choice of or access to certain eligibility pathways. In addition, federal and State policies also impose restrictions. The most common include:

    a. Retroactive coverage. Under the State's Section 1115 demonstration waiver, retroactive coverage is not available to MACC group beneficiaries, including those who qualify for LTSS. Retroactive coverage is an included benefit through many of the IHCC pathways in which the State determines eligibility for Community Medicaid and Medicaid LTSS, as indicated in Subchapter 5 Part 3 of this Chapter.

    b. Other Health Coverage. Federal law precludes persons who are eligible for or enrolled in Medicare from obtaining coverage through the MACC group for adults, ages 19 to 64. Other forms of health coverage, including both commercial insurance and government-sponsored, are generally not a bar to Medicaid eligibility through the MACC and IHCC pathways. In addition, the State's health insurance payment program – RIte Share – makes it possible for beneficiaries who have access to cost-effective Employer-Sponsored Insurance (ESI) to maintain coverage through work once they become Medicaid-eligible. Medicaid Code of Administrative Rules, RIte Share, provides details on RIte Share. The MPPP is also available to provide financial help to cover the costs of Medicare coverage for low-income elders and adults with disabilities.

    c. Former SSI Recipients. All former SSI recipients who lose cash benefits due to increases in income are evaluated first for the SSI protected status groups located in Subchapter 5 Part 1 of this Chapter. In instances in which eligibility in one of these groups is unavailable, the person will be evaluated for the MACC and/or IHCC Community Medicaid pathways, to the extent the other limiting factors in this subsection allow, and provided with a choice of coverage options as appropriate.

    d. Age. In general, persons 65 and older are ineligible for MAGI-based MACC group eligibility. Parents/caretakers of a Medicaid eligible child in this age group, including those enrolled in Medicare, are the only exceptions. Children and youth under 19 are generally not eligible in the IHCC groups. However, pregnant women, parents/caretakers and children with high health care expenses who have family income above the MACC group limit may seek MN eligibility through Community Medicaid using the SSI methodology.

IHCC resource and deeming rules apply, unless the child is seeking LTSS through the Katie Beckett eligibility provision.

e. LTSS Preventive Level Services. These services are only available to adults with disabilities and elders who are eligible through the Community Medicaid pathways as EAD or MN.

f. Need for LTSS. All LTSS applicants are subject to a review of the transfer of assets, in accordance with applicable federal requirements and State laws and regulations governing estate recoveries, irrespective of whether initial income eligibility is determined using the MAGI standard or the SSI methodology. LTSS beneficiaries who are eligible through the MACC group pathway ARE NOT subject to resources limits, however.

g. Medically Needy (MN) Eligibility. For all non-LTSS applicants, MN eligibility is considered the last option for obtaining Medicaid coverage, both because the burden on beneficiaries is the most significant and the opportunities for coordinating and managing care are so limited. There is not a MN option for MACC group adults, unless they are eligible through the pathway for parents/caretakers. Accordingly, for these adults IHCC eligibility is the only avenue to MN coverage. For LTSS applicants, MN eligibility is also the last option; though the income eligibility limits are higher than through other eligibility pathways, beneficiary liability tends to be as well. In addition, access through this pathway limits access to SSP assistance (i.e., only available if income is at or below 300% of SSI) and the range of LTSS settings in some instances.

h. MPPP. Elders and adults with disabilities who are participating in the MPPP are only eligible for the MACC group for parents/caretakers. Otherwise, MPPP participants must access Medicaid financial help through the IHCC groups. In addition, participation in the MPPP has the potential to affect eligibility for Medicaid health coverage through the Community Medicaid MN pathway. As indicated in Subchapter 5 Part 2 of this Chapter, Medicare premiums are health expenses that count toward the amount a person must spenddown in order to obtain Medicaid coverage during the six month MN period. MPPP participants are not permitted to use these expenses toward a spenddown as they are paid by the State.

2. Eligibility Across Pathways – Eligibility specialists and application assisters must be available to provide applicants and beneficiaries with information about the impact the limits above have on the choice of eligibility pathways. Such information is also provided with paper applications and

will be built into the self-service portal to assist applicants and beneficiaries in making reasoned choices about their Medicaid health options. The table below summarizes the major cross pathway eligibility opportunities by major Medicaid populations.

Selected Eligibility Cross Pathways By Population **(Excludes beneficiaries eligible on basis of other programs)**			
Population	**MACC Group – MAGI-Based** **(No Retroactive Coverage)**	**IHCC Group SSI methodology-based** **(Retroactive Coverage Possible)**	**Both MACC and IHCC Eligibility determined using both**
Children, no need for LTSS	Up to MACC income limit (261% of FPL +5% disregard)	MN only if income above MACC limit and have high health expenses	Not Applicable
Child requiring LTSS-health institution over 30 days	Not applicable	MN-LTSS	Not Applicable
Child requiring LTSS-HCBS	Up to MACC income limit for children	Family income above MACC limit – Katie Beckett eligibility based on child's income only MN-LTSS	Not Applicable
Pregnant Women	Up to MACC income limit (253% of FPL + 5% disregard)	EAD or MN if disabled, but only until next renewal or birth of baby, whichever comes first; MN if non-disabled and income above MACC limit and have high health expenses	Option for MACC and MPPP if have Medicare

		LTSS	
Adults 19-64, no Medicare	Up to MACC income limit (133% FPL + 5% disregard), LTSS with no resource limit	EAD or MN if have a disability and are seeking retroactive coverage LTSS	Not Applicable
Adults with disabilities 19-64	If no Medicare, up to MACC limit for adults, including while awaiting a disability determination by the State or SSA	EAD, MPPP and/or MN Sherlock Plan if working LTSS	Option MACC group for parents/caretakers and MPPP
Elders	Only if a parent/caretaker	EAD, MPPP, MN LTSS	Option MACC group for parents/caretakers and MPPP

3. Continuing Eligibility Reviews Prior to Termination of Coverage – The State must evaluate whether a beneficiary may qualify for Medicaid health coverage through an alternative pathway prior to the termination of eligibility. This requirement only applies when the reason for the termination is a change in an eligibility factor (e.g., age, income, resources or disability, relationship, etc.). The State uses any information known about the beneficiary through his or her account and electronic data sources to evaluate the options for continuing coverage. A beneficiary is informed in writing about this evaluation, which is referred to as an ex parte review, and of any additional materials that must be submitted to determine whether alternative forms of eligibility exist at least ten (10) days prior to the date the eligibility termination takes effect. Such notification is provided more than thirty (30) days in advance of the date of the agency action whenever feasible. In addition to evaluating beneficiaries for other forms of Medicaid eligibility, anyone under age 65 is also considered for commercial coverage with financial help through HSRI.

2.7 Renewal of Eligibility for IHCC Groups

2.7.1 Scope and Purpose

A. One of the principal requirements of Medicaid is that continuing eligibility must be re-evaluated at least once a year. For the IHCC groups, this annual review was called a “redetermination” and, accordingly, often required beneficiaries to reapply for coverage. Current federal regulations [42 CFR 435.916(b)] governing the IHCC groups now require that these annual reviews consider only those eligibility factors that are subject to change. Accordingly, the continuing eligibility of the IHCC group beneficiaries receiving Community and LTSS Medicaid is now conducted by requiring them to review their account information on key eligibility factors, as updated by internal and external data sources, and report any inaccuracies or changes in the manner described in this section.

B. The factors subject to change include income, resources, household composition (e.g., as a result of births, deaths, divorce, etc.), disability or clinical factors, access to third-party coverage, and changes in family size (e.g., due to death, marital status, birth or adoption of child), and/or immigration status. LTSS beneficiaries may be required to provide additional information related to change in care settings. Note: The provisions in this section do not apply to beneficiaries who are deemed eligible due to participation in other programs (e.g., SSI recipients), or that are determined eligible by the SSA. Special MPPP renewal provisions also apply.

2.7.2 Agency Responsibilities

A. IHCC group renewals are conducted in accordance with the following:

1. Frequency – The Medicaid renewal process occurs at least once every twelve (12) months and no more frequently unless as result of a change in eligibility factors.

2. Types of Information – The eligibility renewal is based on information already available to the full extent feasible. Such information may be derived from reliable sources including, but not limited to, the beneficiary’s automated eligibility account, current paper records, or databases that may be accessed through the IES. Information about eligibility factors that are not subject to change or matters that are not relevant to continuation of Medicaid eligibility are not requested or used at the time of renewal. Factors that are not subject to change include, but are not limited to, U.S. citizenship, date of birth, and Social Security Number.

3. Notice – Timely notice must be provided of:

    a. Renewal Date. A notice of the date of the annual renewal is sent at least thirty days (30) days prior to the renewal date. The beneficiary

is also provided with a pre-populated form containing information from the Integrated Eligibility System and other sources on each relevant eligibility factor. In instances in which the Medicaid beneficiary is required to take action in addition to completing the pre-populated form, such as providing paper documentation or explaining a discrepancy, a timeline is included for completing the action as well as indication of the consequences for failure to do so.

b. Renewal Action. At least ten (10) days prior to the renewal date, Medicaid beneficiaries are provided with a notice stating the outcome of the renewal process and explaining the basis for any agency action – continuation or termination of eligibility. The notice also contains the right to appeal and obtain an administrative fair hearing. Beneficiaries are also notified that they have the right to have their health coverage continued while awaiting a hearing if an appeal is filed in ten (10) days from the date of the renewal notice is received. The date the notice is received is presumed to be five (5) days from the date on the notice.

4. Consent – At the time of initial application, Medicaid beneficiaries sign or provide an electronic signature giving the State consent to obtain and verify information through external data sources and from certain providers for the purposes determining eligibility and renewing health coverage. The first time IHCC group beneficiaries are renewed through the IES, such consent must be provided if it does not already exist.

5. Modified Passive Renewal – All IHCC beneficiaries are subject to a modified passive renewal process that proceeds as follows:

a. Initial Automated IES Renewal. During the first automated IES renewal, IHCC beneficiaries are provided with a pre-populated form containing all information related to eligibility on record, typically in their IES accounts, that has been self-reported and/or obtained through electronic data matches at application, post-eligibility verification, and change reports. Beneficiaries are required to review this form, make any necessary changes and required actions, and then attest to the accuracy and completeness of the information provided on any eligibility factor subject to change. In addition, the Medicaid beneficiary must provide consent to the EOHHS permitting automated data exchanges and/or retrieval of information on eligibility factors from outside sources for all future renewals.

b. Continuing Renewals. After the initial automated renewal, IHCC beneficiaries receive a pre-populated form and are only required to return the form to self-report changes in eligibility factors or to respond to agency requests for information or documentation. If no

such changes are required, the beneficiary is not required to take further action. Medicaid health coverage is renewed automatically and a new eligibility period is established.

2.7.3 Beneficiary Responsibilities

Medicaid beneficiaries must meet the requirements associated with making and completing an application as set forth in § 2.5 of this Part.