Resuming Routine Eligibility Operations: Frequently Asked Questions (FAQ) for Partners & Stakeholders

Updated as of 06/20/2023

Resuming Routine Eligibility Operations

1) **What does it mean that Ohio will now resume routine eligibility operations, and what does it have to do with members?**
   "Routine eligibility operations" refers to Ohio Medicaid's annual redetermination of member eligibility. Every individual receiving healthcare coverage through a state Medicaid program must prove their eligibility annually through a process called "Medicaid renewal" or "Medicaid redetermination." However, at the start of the COVID-19 pandemic, states stopped formally conducting redeterminations in exchange for much needed federal funding to manage the healthcare crisis.

   In December 2022, Congress passed the Consolidated Appropriations Act, 2023 (CAA) that, among other things, required Medicaid agencies to return to normal operations. This includes conducting annual eligibility renewals to confirm enrollees meet state and federal enrollment qualifications.

2) **When did the return to routine eligibility operations period begin in Ohio?**
   Ohio returned to routine eligibility operations (i.e. "unwinding") on February 1, 2023. ODM will review eligibility for ALL current Medicaid members over a 12-month timeline, which aligns with each member's renewal date. For example, renewal packets for members with a renewal date in April 2023 were mailed on March 1, 2023, and were due on March 31, 2023.

   For key dates related to Ohio's return to routine eligibility operations, please see the timeline on slide 11 of, "A Return to Routine Eligibility Operations" webinar slides published here.

3) **How can partner organizations help Medicaid members with the return to routine eligibility operations period?**
   Providers play an important role in this process by communicating changes to members and providing information regarding steps they need to take to prepare for the return to routine eligibility operations. We ask that organizations interacting with Medicaid members communicate key messages outlined in the Partner Packet, and summarized below:
   1. Communicate to Medicaid members the importance of updating their contact information and responding to requests for information.
   2. Share with members the importance of responding to their renewal packets.

3. Ensure Medicaid members take the necessary steps to transition to other coverage if they're no longer eligible for Medicaid.
4. Children may be eligible for coverage even if their parent/legal guardian is no longer eligible.

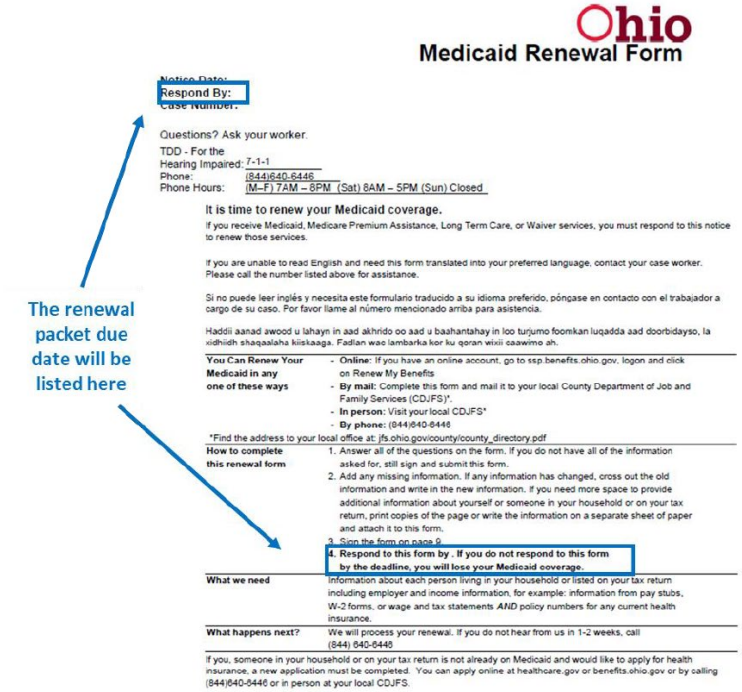
The Partner Packet and other resources may be found here. Versions are also available in the top five languages Ohio members read: Spanish, Nepali, Arabic, Somali, and Russian. Translated copies are available here.

Renewing Medicaid Coverage

4) What is a Medicaid renewal packet?

The Medicaid renewal packet is a **pre-populated** form that lists information members previously provided about their household, income, and other details to determine their Medicaid eligibility. Members should review the packet and confirm or correct the data contained in the form.

Please note: any member who receives a renewal packet must complete and return it by the deadline specified - **even if there are no changes**. The due date can be found on the first page of the renewal packet as depicted in the example shown below.



An example of a blank renewal packet can be found on the ODM Resuming Routine Medicaid Eligibility Operations webpage.

5) When will members receive a Medicaid renewal packet?

Not every Medicaid member will receive a renewal packet. The state will first attempt to renew members' coverage without contacting them. About sixty days before their enrollment anniversary, Ohio Medicaid will try to confirm a members eligibility through an automated process that scans specific federal systems and databases for information on income, household, assets, and more. This process is called "ex parte" .

If a member is determined eligible through ex parte , they will not receive a renewal packet. Instead, they will receive a letter confirming their reenrollment.
If the state is unable to verify a member's eligibility via ex parte , a renewal packet will be mailed to their address on file 30 days before their renewal date, prompting them to go through the renewal process. Members should make sure their contact information is up to date, so the renewal packet is mailed to the correct address.

Members should complete the renewal packet for every family member enrolled in Medicaid, note all changes, and provide new information as needed. They may be asked to provide additional information if they've experienced a change, such as proof of income and resources, proof of citizenship or non-citizen status (only if it has changed), and pregnancy status, if applicable.

6) **How do members renew their Medicaid coverage?**
There are multiple ways for members to renew their coverage. Individuals who were not able to have their Medicaid renewed through ex parte will receive a pre-populated renewal packet in the mail and in their existing Self-Service Portal (SSP) account. The member renewal process includes updating, signing, and returning the renewal packet. A member's completed renewal packet(s) can be returned in any of the following ways:
   - **In-person or by mail** by returning their completed and signed renewal packet to their local CDJFS office. Members can find contact information for their CDJFS by choosing their county from the dropdown at: medicaid.ohio.gov/dropdown.
   - **Over the phone** by calling 1-844-640-6466, Monday through Friday 8 a.m. to 4 p.m. ET.
   - **Online** through the Ohio Benefits eligibility portal. Members can visit ssp.benefits.ohio.gov *only if they have already created a Self-Service Portal account*. Otherwise, they must submit the renewal through one of the methods listed above. Even if they can't complete their renewal in the Self-Service Portal, they can still use their account to report changes and upload documents.

   For additional questions on renewing Medicaid coverage, members can call 800-324-8680, Monday through Friday 8 am. to 4 p.m. ET.

7) **How will members or their authorized representative(s) know their renewal date?**
Members or their authorized representative(s) will receive a letter from their CDJFS and/or their Managed Care Plan with this information, approximately 30 days before the month their renewal is due. In order to receive this notice, members should make sure their contact information is up to date.

8) **What is an authorized representative?**
Medicaid members can ask to be represented by someone of their choosing to serve as their proxy in the application and renewal processes and to receive decisions regarding their Medicaid coverage. These member-selected individuals serve as an "authorized representative" and must be age 18 or older and able to stand in the member's place. Members are asked to submit a written statement naming the authorized representative and the duties he or she may perform on the member's behalf. The form to designate an authorized representative may be found on the Ohio Medicaid website here.

9) **What if members miss the due date to return their renewal packet?**
Members should send in their renewal packet even if the due date has passed. If they are eligible but miss the deadline, they have 90 days to reenroll without needing to submit a new application. To reenroll, members can contact their local CDJFS or call 844-640-6446. Assistance is available by phone Monday through Friday 8 a.m. to 4 p.m. ET.

10) **What if a renewal packet is returned to the state as undeliverable?**
If renewal mail (renewal packet or subsequent requests for information) is returned as undeliverable, the county agency is required to attempt to contact the member using two modalities, if available. This could mean reaching out via mail to the forwarding address provided and calling the member by phone or calling the member and sending an email.

Medicaid Eligibility

11) **How will members know if they will no longer be covered by Medicaid?**
Approximately fifteen days before the day their coverage will end, members will receive a Notice of Action letter explaining who in their household is ineligible and for what reason.

12) **Why would a member's coverage be discontinued?**
There are several reasons why members or someone in their household may have their Medicaid coverage discontinued.

Common reasons include:

- Having income that exceeds the income limit for their family size
- Living outside of the state of Ohio
- For programs that have a resource requirement, having countable resources that are higher than the allowable resource limit.
- Lack of response to requests for additional information by the due date. However, as noted above, even if the due date has passed, members should still send in their renewal packet or the requested verifications

13) **Where can income guidelines for member eligibility be found?**
Eligibility criteria, including income, vary based on the Ohio Medicaid program. To learn more about the financial requirements of different programs or to view examples of financial eligibility by monthly income for children, families and adults or aged, blind, or

disabled individuals please visit the Ohio Medicaid website at: medicaid.ohio.gov/families-and-individuals/coverage/who-qualifies.

Transitioning to New Coverage

14) If members are no longer eligible for Medicaid, where can they learn about other healthcare options?

If members are not eligible for healthcare coverage from Medicaid, low-cost healthcare coverage may be an option for them through the federally facilitated Marketplace at healthcare.gov. Losing Medicaid coverage is a Qualifying Life Event (QLE), which allows members to enroll in a Marketplace plan outside of the open enrollment period. Additionally, they may be eligible for discounts that can lower the cost of their coverage.

Assistance is available at no cost to members to help them understand their healthcare coverage options at no cost to them. Trained, licensed navigators from Get Covered Ohio will provide free and unbiased help. Members can go to getcoveredohio.org or call 833-628-4467. Navigators can help them in-person, online, or over the phone. If they are told that they are no longer eligible for Medicaid coverage, they should enroll in a Marketplace plan as soon as possible to avoid a gap in their healthcare coverage. If they are enrolled in Medicaid Managed Care, their Managed Care plan will likely reach out to them to inform them of your options as well.

15) Are children or dependents eligible for coverage even if their parents are not?

Children may be eligible for coverage even if their parent/legal guardian is no longer eligible.

Ohio Medicaid offers a program called "Healthy Start" that is available to insured or uninsured children (up to age 19) in families with income up to 156% of the federal poverty level (FPL). The Children's Health Insurance Program (CHIP) is also available to uninsured children (up to age 19) in families with income up to 206% of the federal poverty level. To estimate their household's potential eligibility for Medicaid, CHIP, or other health insurance programs, members can explore publicly available calculators such as the Low Cost Marketplace Health Care, Qualifying Income Levels calculator published at healthcare.gov.

More information is available at medicaid.ohio.gov/children-and-families. Members can also contact your CDJFS for more information.

Additional Information

16) Where can members get more information if they have additional questions?

For more information about the return to routine eligibility operations:

- Head to the Ohio Department of Medicaid's dedicated webpage by clicking here
- Call 1-844-640-6466, Monday through Friday 8 a.m. to 4 p.m. ET
- Submit an inquiry to the ODM contact page here