Medicaid LTSS Renewals

Frequently Asked Questions

Since November 20, 2019, we have shared that we are strengthening our compliance with federal requirements by changing our Medicaid Long Term Services and Supports (LTSS) application and renewal process. Federal policy [1] requires LTSS recipients to renew their eligibility for LTSS benefits every 12 months. Failure to comply with this federal requirement leads to a termination of LTSS benefits. The only exception is individuals who are on Social Security Insurance (SSI) are NOT subject to financial renewal. The following are frequently asked questions that we have received about this process.

Question: Who is an LTSS recipient?

Answer: LTSS is the Medicaid wraparound program for individuals who receive an enhanced level of services due to a developmental disability and/or clinical need. One may be on LTSS if Medicaid is paying for any of the following:

- A nursing home stay that is more than 30 days
- Residence in an assisted Living facility
- Services in the home through a homecare agency
- Services in the home through the Shared Living or Personal Choice Program
- Personal care and/ or employment services through BHDDH

Question: Do all LTSS Beneficiaries need to complete an annual financial renewal?

Answer: No, individuals eligible for Social Security Insurance (SSI) are not subject to State financial renewals. Please note that SSI is the monthly payment of up to $771 and is different from Social Security Disability Insurance. Office of Healthy Aging programs such as CNOM are also exempt from financial renewal.

Question: When will denials based on failure to return renewals begin??

Answer: Beginning at the end of January 2020, LTSS benefits will be **terminated** if renewal packets are not received and scanned into the eligibility system by their due date. A termination notice will be sent 15 days before the termination if effective. This provides our customers the opportunity to appeal the pending termination and/ or return the renewal packet before the termination is effective.

In many cases, DHS needs more information to determine initial eligibility upon receipt of an initial application or to redetermine eligibility. When this happens, DHS sends the person a notice of Additional Documentation Required (ADR). **If DHS does not receive all the additional information it requested by the due date, LTSS benefits will be denied or terminated in accordance with state regulation [2].**

Question: How do I know when an LTSS recert is due?

Answer: Beneficiaries will receive a pre-populated recertification packet in the mail 30 days before the due date and 60 days before the termination date. EOHHS is also working with providers and partner agencies to provide lists of upcoming recertification dates.

Question: How can I help an LTSS Beneficiary complete their recertification?

Answer: In early December 2019, we sent a checklist for those who need to renew, or loved ones and facility staff who may help their family, patients and residents with the renewal process. It can be found at: http://www.dhs.ri.gov/Documents%20Forms/LTSSBenefitsHelpW%E2%81%ACithRenewal.pdf.

If you do not have the pre-populated packet, Medicaid LTSS Renewal forms can be found here: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Applications/RecertificationForm.pdf

Question: What happens if an LTSS Beneficiary is closed for failure to return a recertification?

Answer: If you can return the packet within 30 days of the client's termination, an LTSS worker will reinstate the case with no break in coverage. If the client was disenrolled from a Managed Care Plan, they will be re-enrolled, but not retroactively. If it has been more than 30 days, we will need a new LTSS application.

[1] 42 CFR § 435.916(b)
[2] 210-RICR-50-00-4