

MISSISSIPPI DIVISION OF MEDICAID

Eligibility Policy and Procedures Manual

101.01 INTRODUCTION

This chapter provides guidelines for processing applications and redeterminations for all Medicaid coverage groups and the Children's Health Insurance Program.

The application process consists of all activities completed during the timely processing period from the time a signed application form is received by the regional office until a notice of approval or denial is mailed to the applicant.

A redetermination is a full review of all variable eligibility factors, conducted at specific intervals for each recipient, to determine whether or not eligibility continues. A redetermination is similar to an initial eligibility determination; however, basic information, such as age, citizenship, Social Security Number, etc., does not have to be re-verified.

101.02 GENERAL INFORMATION

101.02.01 ACCESS TO THE APPLICATION PROCESS

Access to the regional office should not be a barrier for individuals wishing to apply. Each office where Medicaid Specialists are located should be accessible for handicapped persons.

There may be times when individuals coming to the office or an out-stationed site make staff aware that they are unable to enter the facility due to illness or incapacity. When this occurs, appropriate staff will go to the person to provide the services needed.

Each Regional Office:

- Provides adequate physical facilities to receive persons who come to the office in orderly surroundings.
- Receives courteously and promptly all persons who come to or contact the office.
- Provides an application form to anyone who requests one.
- Allows any individual the right to apply for any benefit, regardless of circumstances. This includes allowing a clearly ineligible individual to apply if he desires.
- Communicates in a clear and courteous manner information regarding services offered through the agency.

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ACCESS TO THE APPLICATION PROCESS (Continued)

- Determines as soon as possible if the person asking for help is seeking a type of assistance which the agency offers. If the individual is not requesting a type of assistance offered by the regional office, he should be referred to another community agency or resource to meet his needs, if one is available.

101.02.02 SPECIAL ASSISTANCE

Each office is required to provide services to the limited English proficient, deaf, blind and disabled applicants, who are mentally or physically impaired and lack someone to act for them.

The instructions below provide guidance for communicating with any applicant or recipient, who is known to be deaf, hard of hearing, blind or visually impaired, or otherwise limited English proficient, illiterate, and/or requires communication assistance.

- **Blind Applicants** – Read forms to the applicant in their entirety and assist in completion of the forms. Explain the various program requirements and services offered through the agency and answer any questions the applicant may ask.
- **Deaf Applicants** – When needed, secure a person proficient in sign language or communicate in writing to relate an explanation of the programs and to answer any questions, and assist in the application process.
- **Illiterate Applicants** – Read forms to the applicant in their entirety and assist in the application process. Explain the various program requirements and services offered through the agency in terms and phrases which the applicant can understand.
- **Language Barrier Applicants** – When interpreter services are needed, use the Language Line to secure the assistance of an interpreter capable of communicating in the applicant's language to assist in the application process and relate the services offered.

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101.02.03 REASONABLE EFFORTS TO ASSIST ALL APPLICANTS

It is required that specialists make reasonable efforts to assist all applicants in order to have the applicant's eligibility determined. Assistance includes, but is not limited to, the following:

- Help with forms completion;
- Help with securing a representative, if needed;
- Help in obtaining necessary information from third parties; and
- Providing information that will assist the applicant in making informed decisions about Medicaid eligibility. Medicaid program policies are public information. Each applicant has a right to know the policies that will impact his eligibility.

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101.03 DEFINITIONS

101.03.01 **APPLICANT**

An individual whose application has been received by the Division of Medicaid.

101.03.02 **RECIPIENT/BENEFICIARY**

An applicant approved for and receiving benefits.

101.03.03 **INCAPACITATED INDIVIDUAL**

An individual who is unable to act on his own behalf due to a physical or mental condition.

101.03.04 **INCOMPETENT INDIVIDUAL**

An individual adjudged to be mentally incompetent by a court.

101.03.05 **INDIVIDUAL WITH LIMITED ENGLISH PROFICIENCY (LEP)**

An individual who is unable to communicate effectively in any language other than his native language.

101.03.06 **SENSORY IMPAIRED INDIVIDUAL**

An individual who has a partial, profound or complete loss of hearing or sight.

101.03.07 **LEGAL GUARDIAN OR CONSERVATOR**

A person who has court documents which prove a legal guardianship or conservatorship has been established for the applicant. The application is filed in the name of the applicant; however, the guardian or conservator must provide eligibility information and sign the application form.

101.03.08 **AUTHORIZED REPRESENTATIVE**

A person who is acting responsibly for the applicant with his knowledge and consent. The authorized representative has knowledge of the applicant's circumstances and is usually a relative or close friend. The authorized representative must be authorized in writing by the applicant to act on his behalf. The application is filed in the name of the applicant. The authorized representative can provide eligibility information and sign the application form.

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DEFINITIONS (Continued)

101.03.09 DESIGNATED REPRESENTATIVE

A person acting responsibly for an applicant because the physical or mental condition of the applicant is such that he cannot authorize anyone to act for him nor can he act for himself. The designated representative has knowledge of the applicant's circumstances and is usually a relative or close friend. The application must be filed in the name of the applicant with the designated representative providing the eligibility information and signing the application form.

101.03.09A Documenting Authorized and Designated Representative Status ❖ **Aged, Blind and Disabled Programs**

The Client's Designation section of the DOM-302, Designated Representative Statement, is used to verify authorized representative status. The applicant and representative will both sign the form.

The section of the DOM-302 entitled, "Statement of Self Designation by Representative", is used to document designated representative status. The representative will sign the form.

101.03.09B Documenting Authorized and Designated Representative Status ❖ **Families, Children and CHIP Programs**

When the FCC head of household is unable to act on his own behalf, a representative may be designated. The head of household must sign the DOM-FCC-302, Designated Representative Statement, permitting an authorized representative to participate in the interview and eligibility process on behalf of the HOH.

A non-applicant caretaker, who is not the legal parent of the applicant children, is a designated representative. The section of the DOM-FCC-302, entitled Statement of Self Designation by Representative, must be completed when this situation exists.

Self-designation is not required when the non-applicant caretaker is a legal parent of one or more of the applicant children.

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DEFINITIONS (Continued)

101.03.10 **APPLICATION**

An application is the action by which an individual indicates his intent to apply for medical assistance.

101.03.11 **APPLICATION FORM**

All applications must be filed on the Application for Mississippi Health Benefits form, the Mississippi Medicaid Aged, Blind and Disabled Medicaid Programs form or an exact facsimile of these forms. The application form is a legal document, completed by the applicant or a person acting on behalf of the applicant, that signifies intent to apply and:

- Is the official agency document used to collect information necessary to determine eligibility;
- Is the applicant's formal declaration of financial and other circumstances at the time of application;
- Is the applicant's certification that all information provided is true and correct;
- Provides notice to the applicant of his rights and responsibilities; and
- May be introduced as evidence in a court of law;

101.03.12 **REQUEST FOR INFORMAL MEDICAID ELIGIBILITY OPINION**

An individual seeking assistance from other social service agencies may be required to obtain a statement from the Division of Medicaid that he is not eligible for Medicaid in order to obtain that agency's services. If the individual indicates through questioning that none of the categorical requirements would be met, i.e., the person is not aged, blind, disabled, pregnant, under age 19 or part of a family with dependent children, the regional office may provide the individual with a statement that he is not eligible based on the self-declared information. The statement must also explain to the individual that the decision is not an official denial and cannot be appealed. If an official denial notice is required, an application must be filed and a decision rendered after all eligibility factors have been examined according to policy. In addition, the statement issued by the office cannot be used to indicate a person's ineligibility due to financial or other non-categorical eligibility criteria. If the person appears categorically eligible, an application must be filed to obtain an eligibility decision.

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101.03.13 ABD RESOURCE ASSESSMENT

When either member of a couple, the Institutional Spouse (IS) or Community Spouse (CS), or a representative acting on behalf of either the IS, CS, or the couple, requests an assessment of the couple's resources, the regional office will use the following guidelines:

- An assessment is separate from an application for Medicaid. If the IS wishes to apply for Medicaid, an assessment is not required. Resources will be evaluated under Spousal Impoverishment rules and appropriate notice of eligibility will be issued.
- When the couple only wants to know how Medicaid will evaluate their total resources if an application were filed, an assessment is required.
- If one spouse has not yet entered an institution on the date the assessment is requested, an assessment cannot be provided.
- An assessment is a "snapshot" of the couple's total countable resources in the month of the institutionalization, i.e., what was true in the month the IS entered an institution for 30 consecutive days or longer on or after 9/30/1989.
- An assessment provides a written evaluation of resources to the couple giving the following information:
 - Total value of countable resources;
 - The basis for the determination;
 - The CS' share based on the maximum standard allowed as of the month of the assessment;
 - Whether the IS would be currently resource-eligible if an application were to be filed.
- A "Resource Assessment Notice" will be used to document the information specified above to the couple or their representative.

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101.04 FILING THE APPLICATION

Individuals inquiring about program eligibility requirements should be informed of their opportunity to apply. If an application is requested, the regional office must provide an application to the individual or mail it, as applicable. If another person or agency refers the name of an individual in need of medical assistance to the regional office, an application will be mailed if an address is available.

101.04.01 RIGHT TO APPLY

Individuals wishing to file an application must be afforded the opportunity to do so without delay. When an individual inquires about making an application at any regional office, an application form must be provided and the person offered the opportunity to file that day. A clearly ineligible person may file an application that must be accepted by the regional office and then denied.

101.04.02 ASSISTANCE WITH APPLICATION

The agency must allow an individual or individuals of the applicant's choice to accompany, assist and represent the applicant in the application or redetermination process.

101.04.03 APPLICATION FILE DATE

The application file date is the date a valid application form is received by the agency. To be valid, the application must be a Division of Medicaid application form or an exact facsimile and it must be signed by the applicant or his representative. Applications may be received by a regional office in one of the following ways:

- In person in any regional office, official out-stationed location or other location outside the regional office where eligibility staff are on official duty, such as a nursing home, hospital or other public facility;
- By mail in any regional office;
 - Applications received by mail which arrive after the end of the month, but were postmarked by the last day of the month will be considered to have been received by the regional office on the last day of the month in which they are postmarked.
- By fax or electronically in any regional office;

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APPLICATION FILE DATE (Continued)

- Faxed applications will be accepted as filed on the date received. However, the application with original signature must be provided and filed in the case record.
- Scanned applications submitted electronically are handled in the same manner as faxed applications.

101.04.04 **PROTECTED APPLICATION DATES FOR MEDICAID APPLICANTS**

An applicant who applies for Medicaid on any basis is entitled to have eligibility determined under all available coverage groups. Therefore, an individual who files an FCC application does not also have to file an ABD application to be evaluated for potential eligibility in an ABD program and vice versa. Any application received by the regional office must be evaluated across ABD and FCC program lines to determine if eligibility exists under any category of Medicaid coverage.

This also includes applications filed through another certifying agency, such as the Social Security Administration (for SSI applicants). If an individual is denied SSI, but would qualify in any available Medicaid-only coverage group, the regional office is required to use the SSI application date as the protected filing date for Medicaid benefits. If the individual is eligible for Medicaid-only, the regional office must determine eligibility using the SSI application date as the Medicaid application date. Additional information may be needed to determine eligibility; however, the application date is the SSI application date and the case must be documented to reflect this.

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101.04.05 WHO CAN FILE THE APPLICATION

An application can be filed by one of the following individuals, as applicable to the case:

- Adult applicants;
- Certain minor applicants, including;
 - A pregnant minor of any age requesting coverage solely due to pregnancy or
 - A married minor living with a spouse; or
 - A minor living independently; or
 - A minor living his/her parents and applying only for the minor's own children.
- The parent who has primary physical custody of a minor child;
- Either parent of a minor child when physical custody is equally divided between legal parents;
- The legal guardian or conservator;
- An authorized representative;
- A designated representative

101.04.06 APPLICATIONS RECEIVED FROM MS RESIDENTS OUT-OF-STATE

Applications made for Mississippi residents who are temporarily out of the state may be accepted. Generally the applicant must return to the state before the application processing period ends. However, the application of someone who is hospitalized in another state and planning to return to Mississippi when discharged may be processed in the usual manner. If the application is approved, the specialist must review eligibility every three (3) months to determine the individual's continued intent to reside in MS.

101.04.07 OUT OF STATE APPLICANTS

Applications received from persons residing in another state will be denied and notice mailed to explain that the applicants will need to reapply upon arrival in MS with intent to reside. Persons who are in MS for a temporary purpose, such as a visit, who intend to return to their home out of state are not eligible for Mississippi Medicaid or CHIP. However, applicants must always be given the right to make an application if they wish to do so and receive a decision on their case.

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101.04.08 APPLICATIONS COMPLETED BY TELEPHONE INTERVIEW

For some types of applications, a telephone interview is permissible. When a telephone interview is conducted, the application completed by the specialist will be mailed to the applicant for review and signature. The application file date is the date the application is received back in the regional office with the applicant's original signature, not the date the telephone interview was conducted.

101.04.09 RESIDENCE CHANGE DURING THE APPLICATION PROCESS

If the applicant reports moving to another location within the state during the application process, the application must be completed by the first regional office, and if approved, transferred to the new location. If the application is denied, do not transfer the record until the person reapplies in the second location.

If the applicant reports moving out of the state during the application process, determine when the move occurred. If otherwise eligible, the applicant may be approved for Medicaid for any requested retroactive months through the month of the move. If the applicant would be CHIP-eligible, the application will be denied since CHIP eligibility is for a future month.

NOTE: If only some members of the applicant family are moving from the state, identify the adults and/or children who remain MS residents and handle their ongoing eligibility accordingly.

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101.04.10 WHERE TO FILE THE APPLICATION

Applications should be filed with the regional office that serves the applicant's county of residence. However, applications for individuals living in another RO's service area must be accepted by any regional office. The regional office must review each application upon receipt and confirm the accuracy of the address if there is a question about the responsible office. The following guidelines should be followed based on the appropriate situation:

101.04.10A APPLICATION FILED WITH CORRECT REGIONAL OFFICE

When the application is received by the regional office responsible for the applicant's county of residence, staff will:

- Date stamp the application form to establish the timely processing period;
- Register the application within 48 hours of receipt;
- If the applicant or representative applies in the office and an in-person interview is required or requested, the regional office will provide the opportunity to be interviewed that day.
 - If the individual cannot be interviewed that day, an interview must be scheduled for the next possible date within ten (10) calendar days from the date the application was received.
- If the application is received in the mail or other than in person and an in-person interview is required or requested, the interview must be scheduled within 10 days of the date the application was received and an appointment notice mailed to the applicant.

101.04.10B APPLICATION FILED IN PERSON WITH INCORRECT REGIONAL OFFICE

When the application is filed in person by an applicant who does not live in the regional office's service area, the following procedures will be followed:

- The receiving office will accept the application and date-stamp it to clearly indicate the date of receipt.
 - Applications for individuals who do not live in the RO service area must not be registered in the MEDS or MEDSX systems.
- Processing time begins whenever any regional office receives the application, whether or not it is the appropriate office based on the applicant's residence address.

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APPLICATION FILED IN PERSON WITH INCORRECT REGIONAL OFFICE (Continued)

- The receiving office must offer an in-person interview on the day the application is received if it is filed in person.
 - If the applicant or representative is interviewed, the intake worker will complete the application, answer all questions, explain rights and responsibilities, etc.
 - Copies will be made of the documents and verifications obtained from the applicant. If information is needed, a request will be issued to the applicant.
 - The applicant will be informed of the regional office location that will complete the application and handle future contacts and reviews.
- The receiving office will mail the application (and other information gathered during the interview, if one was conducted) to the correct regional office within 24 hours of receipt of the application.
- The correct office will then register the application within 48 hours of receipt using the actual application date.
 - The actual application date is the date the application was received and date-stamped in the original office not the date the second office receives it.

101.04.10C APPLICATION FILED BY MAIL WITH INCORRECT REGIONAL OFFICE

When the application is filed by mail (or other than in person) by an applicant who does not live in the regional office's service area, the following procedures will be followed:

- The receiving office will accept and date-stamp the application to clearly indicate the date of receipt.
 - Applications for individuals who do not live in the RO service area must not be registered in the MEDS or MEDSX systems.
- Processing time begins whenever any regional office receives the application, whether or not it is the appropriate office based on the applicant's residence address.
- The receiving office must mail the application (with any attachments provided) to the appropriate regional office within 24 hours.

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APPLICATION FILED BY MAIL WITH INCORRECT REGIONAL OFFICE (Continued)

- The correct office will begin processing the application, which must be registered within 48 hours using the actual application date.
 - The actual application date is the date the application was received and date-stamped by the original office, not the date the second office receives it.

When the following circumstances occur, the receiving regional office will be responsible for processing an application outside of the RO's service area:

101.04.11 APPLICATIONS REGISTERED TO THE INCORRECT REGIONAL OFFICE

- If the application is already registered when the receiving office discovers the applicant does not live in the RO service area, the receiving office must complete the eligibility determination.
- Supervisory staff must ensure:
 - The case is completed before it is transferred to the appropriate office; and
 - The applicant is notified of the office which will handle future contacts and case reviews.

101.04.12 APPLICATIONS NOT FORWARDED TO CORRECT OFFICE IN A TIMELY MANNER

- Applications which have not been mailed to the correct regional office by the end of the 2nd day following receipt of the application will be registered and processed by the receiving office.
- Supervisory staff must ensure:
 - The case is completed before it is transferred to the appropriate office; and
 - The applicant is notified of the office which will handle future contacts and case reviews.

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101.05 INTERVIEW

Refer to individual program chapters for specific interview requirements. Whenever an applicant requests an in-person interview, one will be conducted even if the program does not require an interview.

At the interview the specialist reviews household composition and relationships to explain the individuals who are required to be included in the application and/or budgetary process, those who cannot be included and persons whose inclusion is optional. The specific programs and services available to the applicant and/or his family through Division of Medicaid are discussed and any questions the applicant has are addressed. In addition, referrals for services offered by other agencies are made, as appropriate.

101.05.01 INTERVIEW DISCUSSION

Whenever an interview is conducted, the following are specific areas must be addressed, if applicable:

- The agency must allow an individual or individuals of the applicant's choice to accompany, assist and represent the applicant in the application or redetermination process.
- Eligibility requirements for the coverage group(s) the applicant appears potentially eligible in;
- Coverage is limited to only one source of eligibility, i.e., SSI, ABD or FCC. If the individual is eligible under another source, that source must terminate before ABD or FCC eligibility begins.
- Use and purpose of the application, including that the applicant is agreeing to all of the rights and responsibilities specified on the application by signing the form;
- Standards of Promptness;
- Assignment of Third Party Rights;
- Quality Control review process;
- Use of Social Security Numbers in computer matching programs;
- Appeal Rights;

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INTERVIEW DISCUSSION (Continued)

- Child Support Requirements;
- Available services such as the Cool Kids program and the annual physical for adults ;
- Verification requirements and methods to be used to establish eligibility, including collateral contacts, documentary verification and other records;
- Change reporting requirements
- The income of a stepparent cannot make a stepchild ineligible.

The following explanations are specific to ABD and must be addressed as applicable:

- Estate Recovery provision;
- Medicaid Income;
- Income Trust provision.
- The income and resources of a spouse must be considered for the applicant's eligibility in the at-home ABD programs whether the spouse is applying or not;
- For institutional applicants, the spouse's resources must be considered toward the applicant's eligibility. The spouse's income is considered when a spousal allocation is requested.

The following explanations are specific to FCC and must be addressed as applicable:

- All possibilities for Medicaid eligibility must be tested before considering CHIP eligibility. Children who qualify for Medicaid cannot be approved for CHIP;
- Requested verifications must be provided for each person included in the application. Failure to provide information may result in individual or multiple denials, depending on the program or type of verification which is lacking.
- The income of an applicant's spouse must be considered toward the applicant's eligibility unless the spouse receives SSI.
- The income of a legal parent living in the home with applicant children must be considered toward the children's eligibility unless the parent receives SSI.
- Verification of personal information, income and expenses is not needed for household members who are not included in the application process.

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101.05.02 CONCLUDING THE INTERVIEW

At the conclusion of the interview, the applicant or his representative must have an understanding of the following:

- Additional information the applicant must provide or actions he must take for eligibility to be determined;
- Actions the agency must take to determine eligibility,
- Notification, including written notice of approval and issuance of Medicaid or CHIP cards or denial and/or the right to appeal any decision;
- Redeterminations, i.e., annual eligibility reviews for children and annual or more frequent reviews, if necessary, for adults.

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101.06 STANDARDS OF PROMPTNESS

Eligibility must be determined within the appropriate timeframes for the program type as discussed below. If there is a delay in processing, the reason must be clearly documented in the record.

101.06.01 REGIONAL OFFICE RESPONSIBILITIES

Each regional office must have controls in place which ensure timely application processing at all staff levels, including sufficient time for supervisory review and corrections. Applications should generally be processed in the order in which received, taking into consideration promptness and delay in receipt of verifications, and in some cases, urgent need. Under no circumstances should an application be approved without the proper verifications and documented eligibility for each applicant.

101.06.02 EXCEPTIONS TO TIMELY PROCESSING

The agency must determine eligibility within established standards, except in unusual circumstances when a decision cannot be reached because of:

- Failure or delay on the part of the applicant;
- Administrative or other emergency delay that could not be controlled by the agency such as:
 - Staff vacancies or illness of eligibility staff lasting two months or more;
 - Wholesale desk reviews on active cases mandated by court order, Federal regulations of wholesale increase in benefits, such as Social Security, VA, etc., which require extensive staff time;
 - Computer problems arising from control of systems by an outside agency.

Time standards may not be used by the agency as a waiting period before determining eligibility or as a reason to deny eligibility because the agency has not determined eligibility within the time standards.

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101.06.03 STANDARDS OF PROMPTNESS

❖ Aged, Blind and Disabled Programs

Federal rules require that applications be approved or denied, and the applicant notified, within 45 days from the date the application was filed. The processing timeframe is 90 days when a disability determination is required before the eligibility determination can be completed. However, if a separate disability decision is not required, the 45-day standard applies.

The applicable standard of promptness, i.e., 45 or 90 days, is applied to an ABD application from the date an application is filed to the date the notice of decision is mailed to the applicant. When there is a delay, the reason must be documented in the record.

101.06.03A STANDARD OF PROMPTNESS

❖ Families, Children and CHIP Programs

The FCC programs have a 30-day standard of promptness. No more than 30 days may lapse from the date an application is filed to the date the notice of decision is mailed to the applicant. Any delays in processing FCC applications must be client-caused or requested. When there is a delay, the reason must be documented in the record.

CHIP actions must be authorized no later than the last CHIP deadline that falls prior to or on the 30th day after the application date, with CHIP benefits to begin the following month.

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101.07 DISPOSITION OF APPLICATIONS

Specialists must determine eligibility based on information contained on the application form as well as information secured during the application process. Appropriate DOM forms, along with other legal or official documents which support the eligibility decision must be filed in the case record.

As part of the eligibility process, information provided by the applicant and/or obtained from other sources must be verified, documented and evaluated by the specialist prior to making the eligibility decision.

101.07.01 **MAKING AN ELIGIBILITY DECISION**

- **Verified** - Verification is the substantiation, confirmation or authentication of an assertion, a claim or previously submitted information.

The specialist will accept reasonable documentary verification provided by the individual and will be primarily concerned with how adequately the verification proves the statements on the application form.

Verification provided by an applicant or beneficiary must never be discarded, destroyed, ignored or altered.

- **Documented** –All cases must be thoroughly documented. Documentation is the written record of all information pertaining to the eligibility decision.

Case documentation includes the completed application form, the specialist's verbal and written contacts with the applicant, information requested and received from applicant or third party sources, such as governmental or nongovernmental agencies, businesses and individuals, and notification of the eligibility decision.

When an applicant claims no income or resources, the specialist must fully document the facts provided to substantiate these claims. "Applicant states none" is not sufficient documentation. The record must also show why the statement of the applicant or beneficiary is reasonable and acceptable.

When action is taken to deny the application because the applicant has not provided the information necessary to determine eligibility within the specified timeframe, documentation in the record must show an appropriate request(s) was issued to the applicant.

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MAKING AN ELIGIBILITY DECISION (Continued)

- **Evaluated** –Information provided by the applicant or obtained through third party sources must be assessed prior to making an eligibility decision. When information is not logical, consistent or reasonable, it must be resolved prior to determining eligibility.

When there is conflicting information, the reliability of each source of information must be evaluated and the case record should specify which source was accepted and why. The final determination of eligibility is made based on the most reliable source available.

101.07.02 SUPERVISORY REVIEW

Each ABD and FCC eligibility determination must be reviewed by a supervisor, who is responsible for the accuracy, completeness and consistency of information contained in the case record. The supervisor is attesting to the validity of the action taken on the case when it is authorized in MEDS or MEDSX.

101.07.03 CONCEPT OF THE PRUDENT MAN

Evaluation of case information must be based on the concept of the prudent or reasonable man. This concept is taken from the practice of law and refers to the element of judgment that is exercised by persons in making choices, determining goals and in evaluating statements of others.

As indicated, the specialist should seek further information or a logical and reasonable explanation of the circumstances when an applicant declares no income or resources, but states his payments for shelter, utilities, food, etc., are all current. The specialist will ask the applicant to explain how he has managed to pay his expenses when he has no income or how he has managed to pay his expenses when he has no income or resources.

There may be a logical explanation and the applicant may be able to offer evidence that (1) he has had income in the past which has recently terminated; (2) he had resources or cash savings which he has now exhausted; or (3) he has paid his past living expenses by incurring debts, establishing credit, obtaining loans, etc. When the applicant or recipient can offer no logical explanation of how he had paid his past living expenses when he has no income or resources or offers vague explanations, such as “I just get by”, etc., and cannot verify how expenses are being met, then eligibility cannot be determined and the application must be denied or assistance terminated.

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101.07.04 USE OF COLLATERAL CONTACTS

When documents are available from the applicant, the applicant is generally the source used to supply needed verification. However, at times information may also be obtained directly from third parties. The general rule for verification is to verify only the information which is material to the individuals' eligibility.

The specialist has permission to obtain needed verifications based on the signed and dated application form. When it is necessary to request information from banks, insurance companies, or other sources that do not disclose information without a signed release, the DOM-301, Authorization to Release Information, should be used. Public records or records available from other agencies may be consulted without the consent of the individual.

Applicants should not be asked to verify information from sources which the agency has access to. This includes SSI, Social Security and other federal or state benefit information that is available to the agency.

101.07.05 APPLICATION ACTIONS

All applications will be subject to one of the following actions:

- **Approval** – When all of the eligibility factors are met, the application is approved.
- **Denial** – When one or more eligibility factors are not met, the application is denied.

NOTE: Death is not an appropriate reason to deny a Medicaid application. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.

- **Withdrawal** – When the applicant decides to withdraw his request for assistance during the application process, it is not necessary to complete any remaining verification and evaluation.

If the applicant is present, the specialist will obtain the request for withdrawal in writing. When the request to withdraw is not made in person, the specialist will document the case to reflect the specifics of the request. The application will be denied and appropriate notice issued.

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101.07.06 REQUESTING INFORMATION FROM THE APPLICANT

The applicant has the primary responsibility for providing documentary evidence to verify statements made on the application or to resolve any questionable information. When additional information is needed, the applicant must be given written notice of the actions he must take to complete the eligibility process.

This includes a written interview appointment when an application is received by mail or the applicant is unable to complete the interview on the day the application is filed **and** an interview is required or requested.

When an appointment must be scheduled or additional information is needed to complete the application process, the specialist will take action based on program type to ensure applicants are provided a reasonable opportunity to meet the requirements for eligibility, as follows:

101.07.07 INFORMATION REQUESTS **❖ Aged, Blind and Disabled Programs**

The ABD applicant will be issued a 307, Request for Information to provide the information or take other requested action. At the end of this request period, if the ABD applicant has not supplied all necessary information or taken the all necessary action to determine eligibility, a follow-up request via DOM 309, Second Request for Information, will be issued.

101.07.07A REQUEST FOR ADDITIONAL TIME

If the ABD applicant subject to 45-day processing subsequently contacts the agency to request additional time, the specialist will explain the information that is still needed and inform the applicant they have the remainder of the 45-day processing period to provide the information. The specialist will verbally provide the final due date for the information, which will be the 45th day from the application date.

If the ABD applicant needs assistance in obtaining information, the specialist will assist in any way possible. However, if the applicant has not fully complied by the end of the 45-day period, the application must be denied because required verifications were not provided.

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101.07.07B **FAILURE TO PROVIDE REQUESTED INFORMATION**

❖ **Aged, Blind and Disabled Programs**

If the ABD applicant subject to 45-day processing has not fully responded to the DOM-309, Second Request for Information, by the due date and has not contacted the agency to request additional time as discussed above, the pending application will be rejected because of the refusal or failure of the applicant, after due notice, to take all necessary steps to enable the agency to establish his eligibility or ineligibility.

The MEDS denial notice must be documented in the comment section to advise the applicant of the specific information that is the basis for the denial. In addition, the case must be appropriately documented to support all of the actions taken.

101.07.07C **COMPLIANCE AFTER DENIAL**

If the ABD applicant subsequently provides all needed information to complete the application after the denial, but prior to or on the 45th day, the specialist will re-register the application in MEDS using the original application date and process the case based on the most recent application form. There is no requirement to re-interview the applicant or obtain an updated signature on the application form. However, if the information needed to complete the application has not been provided in full by the 45th day, a reapplication is required.

NOTE: If the ABD application is denied because the client did not appear for a required interview, the above procedures are not applicable and a reapplication must be filed.

101.07.07D **APPLICANTS SUBJECT TO 90-DAY PROCESSING**

Applicants, subject to the 90-day standard of promptness, will be denied at the end of the standard of promptness if they have failed to provide all required information.

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101.07.08 **INFORMATION REQUESTS**

❖ **Families, Children and CHIP Programs**

When an interview appointment is needed for the FCC applicant, it will be scheduled within 10 days of the application date using the DOM 307, Request for Information. In addition, general information needed to complete the application process will be requested on the appointment notice.

If additional information is identified at the interview or the applicant needs additional time to provide some or all of the information previously requested, a second 307 will be issued for the information to be provided.

101.07.08A **REQUEST FOR ADDITIONAL TIME**

If an FCC applicant subsequently contacts the agency to request additional time to provide verifications, the specialist will explain the information that is still needed and inform the applicant they have the remainder of the 30-day processing period to provide the information. The specialist will verbally provide the final due date for the information, which is the 30th day following the application date.

If the FCC applicant needs assistance in obtaining information, the specialist will assist in any way possible. However, if the applicant has not fully complied by the end of the 30-day period, the application must be denied because required verifications were not provided.

101.07.08B **FAILURE TO PROVIDE REQUESTED INFORMATION**

❖ **Families, Children and CHIP Programs**

When the FCC applicant is issued a DOM 307, but fails to fully comply, the application will be held until the 15th day following the application date **or** until the request period on the most recent DOM 307 has expired, whichever is later. The application will then be denied, provided the applicant has not contacted the agency to request additional time.

To summarize, the specialist will take the later of the following actions:

- Hold the FCC application until the 15th day following the application date; and then deny if the applicant has not contacted the agency to request additional time; or

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FAILURE TO PROVIDE REQUESTED INFORMATION (Continued)

Families, Children and CHIP Programs

- Hold the FCC application until the request period on the most recent 307 has expired and then deny if the applicant has not contacted the agency to request additional time.

The MEDSX denial notice must be documented using the “Message to be Included in Notice” section to advise the applicant of the specific information that is the basis for the denial. In addition, the case must be appropriately documented to support all of the actions taken.

101.07.08C COMPLIANCE AFTER DENIAL

If any FCC applicant subsequently provides all documentary evidence needed to complete the application after denial of the application, but prior to or on the 30th day following the application date, the specialist will re-register the application in MEDSX using the original application date and process the case based on the most recent application form. There is no requirement to re-interview the applicant or obtain an updated signature on the application form. However, if the information needed to complete the application has not been provided by the 30th day as discussed above, a reapplication is required.

NOTE: If the application is denied because the client did not appear for the interview, the above procedures are not applicable and a reapplication is required.

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101.08 ELIGIBILITY DATES

101.08.01 BEGINNING DATES OF MEDICAID ELIGIBILITY

Medicaid applicants, including an applicant who dies prior to filing an application or dies prior to completion of the application process, may qualify for Medicaid on one of the following dates:

- The first day of the month of the application, provided all eligibility factors are met for the first day of the month;
- The first day of the month after the month of application in which all eligibility factors are met;
- The first day of the first, second or third month prior to the month of application when conditions are met for retroactive Medicaid.

101.08.02 BEGINNING DATES OF CHIP ELIGIBILITY

The benefit start date for CHIP is a future month. Coverage authorized by the 21st day of a month (or the first business day prior to the 21st if it falls on a weekend or holiday) is effective on the first of the following month.

There is one exception for limited retroactive coverage in CHIP. The start date for a CHIP-eligible newborn may be retroactive to the date of birth if:

- The application for the newborn is filed within 31 days of birth; and
- The approval is authorized by the supervisor within 60 days of the application.

The 31-day count for the application to be filed begins the day following the date of birth.

101.08.03 TERMINATION DATES

Eligibility for a Medicaid or CHIP recipient will end on one of the following days of the month, unless otherwise noted:

- The last day of the month in which the client was eligible; or
- The death date of the recipient. or
- The date the recipient entered a public institution.
 - CHIP EXCEPTION: CHIP eligibility is terminated on the last day of the month in which the child entered the public institution.

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101.08.04 RETROACTIVE MEDICAID ELIGIBILITY

Retroactive Medicaid eligibility may be available to any Medicaid applicant who received medical care prior to applying for Medicaid. Applicants may qualify for coverage for a 3-month period prior to the month of the application. Retroactive eligibility can cover all 3 months of the prior period or any month(s) in the 3-month period. In addition:

- Each applicant must be informed of the availability of retroactive Medicaid coverage.
- The applicant's statement is accepted regarding medical expenses incurred in the retroactive period.
- Retroactive Medicaid may also be available to an individual who is added to a case (e.g., child returns home).
- The applicant does not have to be eligible in the month of application (or current month) to be eligible for one or more months of retroactive Medicaid.

NOTE: Children have continuous eligibility. Refer to the FCC program section for instructions on how to handle children who do not have current month eligibility, but are eligible in a retroactive month.

- The applicant or recipient may ask for retroactive Medicaid coverage at any time.
- The date of application, rather than the date of the eligibility determination, establishes the beginning of the three-month retroactive period.
- There is no provision for retroactive coverage in the Qualified Medicare Beneficiary (QMB) program. QMB eligibility begins the month following the month of authorization. It is not appropriate to place a QMB-only approval into an SLMB or QI-1 category of eligibility to provide retroactive payment of Part B premiums for the retro period.

101.08.04A DECEASED APPLICANTS

An application for retroactive Medicaid coverage may be made on behalf of a deceased person. Retroactive eligibility can cover all 3 months prior to the month of application or any month(s) in the 3-month period if the deceased person is found to be eligible.

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101.08.04B SSI ELIGIBLES

Persons eligible for SSI may be eligible for additional months of eligibility beyond the SSI retroactive period. This period of coverage includes the month of application for SSI and any other missing months of eligibility that exist until the month the SSI payment begins. The SSI eligible person must apply for and be determined eligible for ABD coverage for the interim period of missing SSI eligibility.

An application for the interim period of missing SSI eligibility can be filed at any time and may or may not be filed in conjunction with an application for SSI retroactive Medicaid.

101.08.04C DETERMINING RETROACTIVE MEDICAID ELIGIBILITY

❖ Aged, Blind and Disabled Programs

Eligibility in a retroactive month cannot be assumed based on current month eligibility. Determine eligibility for each month separately using the eligibility rules in effect for that month, actual income received in each month and actual resources available in each month.

NOTE: Annual Cost-of-Living Adjustment (COLA) increases in Federal benefits cannot be used to determine ABD eligibility in any given year until the Federal Poverty Level (FPL) limits have been implemented for that year. Therefore, when determining retroactive or ongoing eligibility for the months of January, February and possibly March, the prior benefit amount must be budgeted, rather than the actual amount.

101.08.04D DETERMINING RETROACTIVE MEDICAID ELIGIBILITY

❖ Families, Children and CHIP Programs

Actual income received in the retroactive month(s) must be verified only if the normal income in those months is significantly more or less than the verified income that is used to determine ongoing eligibility. Accept the applicant's statement regarding income sources and amounts in the retroactive period unless there is some reason to question the accuracy of the statement.

For purposes of determining Extended Medicaid eligibility, retroactive Medicaid can be used to determine whether an applicant would have been eligible for Medical Assistance (85) in three of the last six months.

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101.09 PROCESSING APPLICATIONS OF EMPLOYEES AND FAMILY MEMBERS

Applications for DOM employees, members of their households and immediate family members require special processing and maintenance as follows.

- DOM employees must not process their own application, redetermination, or change. They must not directly view, add, remove, replace or edit system information or documents and verifications in the case record.
- Further, DOM employees must not process or maintain case(s) that include a member of their household or immediate family. They must not process the application, redetermination or change on these individuals' cases. They must not directly view, add, remove, replace or edit system information or documents and verifications in the case record.
- Immediate family includes the employee's spouse, children, children's spouses and the following relations to the employee or employee's spouse: mother, father, step-parent, brother, sister, niece, nephew, grandparent, grandchildren.
- Individuals living in the home with the employee are included as immediate family members even if they are not one of the relationships listed above.
- DOM employees, household members and their immediate family members must be marked as DOM employees in MEDS and MEDSX to limit system access to all members of the case. The case records must be maintained in a locked file by the person responsible for the case.
- Cases involving family and friends can potentially represent an impropriety or conflict of interest to an employee; therefore, it is the employee's responsibility to inform the supervisor if the application or case of a family member or friend has been assigned to them.
- DOM employees must never directly or indirectly influence or request that another DOM employee process an application for themselves, family members, household members or friends outside of normal assignment and authorization processes.
- Individuals who fail to follow the guidelines for processing applications for employees and their family members are subject to disciplinary action.

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Procedures for Processing Applications of DOM employees, Members of Their Household or Immediate Family Members

Any application or active case involving a DOM employee, household member or immediate family member, as defined above, in any regional office must be processed using the following guidelines:

The Applicant is	The Person to Interview & Process the Application is	The Person to Review & Authorize the Action is
DOM Employee	Division Director (DD)	Bureau Director, Deputy (BDD)
Employee's Spouse or Minor or Adult Child	Division Director	Bureau Director, Deputy
Other Immediate Family or Household Member	Assistant Supervisor Assigned by DD	Division Director
DD, DD's Spouse or Minor or Adult Child	Bureau Director, Deputy	Bureau Director, Deputy
Other Immediate Family Member or Household Member of DD	Assistant Supervisor	Bureau Director, Deputy
BDD, BDD's Spouse or Minor or Adult Child	Division Director	State Office Manager
Other Immediate Family Member or Household Member of BDD	Division Director	State Office Manager

Prior to authorizing eligibility, the regional Division Director, Bureau Director, Deputy or State Office Manager, as appropriate, will thoroughly review the case and determine the accuracy of the eligibility decision. This may include additional contact with the applicant or others when deemed necessary to make a determination of eligibility.

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101.10 CONTINUOUS ELIGIBILITY FOR CHILDREN

When a child under age 19 is approved for Medicaid or CHIP, eligibility continues for 12 months, regardless of changes in family income and other household circumstances. This policy must be applied when determining and re-determining eligibility for a child under age 19, regardless of category.

Continuous coverage may also be referred to as a protected period because the child cannot lose eligibility in the assigned category, unless one of a limited number of early termination reasons is met. In addition, the child's program cannot be changed (Medicaid to CHIP or vice versa), unless the Head of Household voluntarily requests early termination or the child was approved in error in the current program.

101.10.01 EARLY TERMINATION REASONS FOR CHILDREN

The following reasons may shorten the 12-month certification for a child in FCC or ABD programs, as applicable.

- If a child dies, his eligibility must be terminated.
- If a child moves out of the state, his eligibility must be terminated.
- If a child attains the maximum age for his program and an assessment of continued eligibility indicates the child is not eligible in any other FCC or ABD program, his eligibility must be terminated. Refer to 101.11.05 Exparte Reviews for further discussion on assessing eligibility in another program.
 - When a child in the Disabled Child Living at Home program will age out of this program, continued eligibility must be assessed in another program.
 - When an FCC child turning age 19 is pregnant, the child will be placed in the 88 program through the post partum period if the pregnancy information is verified and coded in MEDSX.
 - At review, an assessment of eligibility in other age-related FCC categories is automated in MEDSX. For example, the uninsured child turning age 6 during the new 12-month eligibility period will move to CHIP the month following his 6th birthday and the 85 child turning age 18 will move to the Poverty Level Medicaid (91) program. The age-out process is discussed further in the FCC Program section.

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EARLY TERMINATION REASONS FOR CHILDREN (Continued)

- When the basis of a child’s eligibility is long term care, eligibility must be terminated if the child is discharged from the facility.
- If a child becomes an inmate in a public institution, his eligibility must be terminated.
- If a child becomes eligible for Medicaid through SSI or Foster Care, coverage authorized through the Medicaid Regional Office will be terminated because the child must have only one source of eligibility. (NOTE: If the child becomes eligible in another program authorized by the RO, termination in the current program must be coordinated with the opening in the new program.)
- If a child is approved in error, his eligibility must be terminated.
- If a child cannot be located after reasonable efforts, his eligibility must be terminated.
- If there is a voluntary request for closure, eligibility must be terminated.

In addition to the above termination reasons, CHIP eligibility will also be terminated within the 12-month period for these additional reasons:

- The CHIP-eligible child becomes covered by other full health insurance;
- The CHIP-eligible child becomes eligible in the 88 program due to pregnancy.

Other changes for children under age 19 in a child or family-related category of eligibility do not affect the child’s eligibility prior to the end of the 12 months of continuous eligibility.

101.10.02 DEEMED ELIGIBLE INFANTS

A deemed eligible infant is a child whose mother was eligible for Medicaid in the child’s birth month; however, there is no requirement that the child remain with the mother. The deemed eligible child has continuous Medicaid eligibility for a 13-month period from his birth month through the month of the first birthday unless one of the above early termination reasons is applicable.

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DEEMED ELIGIBLE INFANTS (Continued)

Specialists have to ensure deemed eligible children are not:

- Terminated prior to completion of the 13th month of Medicaid eligibility; or
- Changed from Medicaid to CHIP prior to completion of the 13th month of eligibility, unless the parent or other responsible person voluntarily requests early Medicaid termination.

The deemed child's eligibility start date should always be his birth month, regardless of the date the agency authorizes eligibility for the child. To terminate eligibility at the end of the deemed period or to make a timely program change from Medicaid to CHIP, the child's time span begin date should be set for the month following the month of the first birthday.

101.10.03 ADULTS

Adults generally have no protected period of eligibility. Changes in income and other circumstances can impact an adult's eligibility as such changes occur. However, women eligible solely due to pregnancy in the Infant Survival (88) program are provided coverage from their first eligible month through the post partum months regardless of any subsequent changes in income, household composition, etc.

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101.11 THE REDETERMINATION PROCESS

Redetermination is the process of verifying whether a recipient continues to meet the eligibility requirements of a particular program. Redeterminations are classified as either regular or special reviews.

A regular review is an annual review of all eligibility factors. A special review is completed when a portion of the case must be re-worked or case information must be updated because of a change.

This chapter contains information about the redetermination process. General information about regular redeterminations is discussed first, followed program-specific discussions about the regular review process. Client notification, change reporting requirements, special reviews, corrective action and reinstatements are also included in this chapter.

GENERAL INFORMATION

101.11.01 REGULAR REDETERMINATIONS

Federal regulations require that the eligibility of every Medicaid and CHIP recipient be reviewed at least every 12 months. Mississippi state law also requires annual reviews. During the regular redetermination process, the recipient's entire situation is reviewed and each eligibility factor is evaluated in a process similar to the initial eligibility determination.

However, in completing the redetermination specialists should only request verification that relates to circumstances that are subject to change, such as income and resources. Recipients must not be asked to provide information that is not relevant to ongoing eligibility or that has already been provided and is not subject to change

Like the application process, a redetermination includes completing an application form, obtaining required verifications and evaluating the information to make an eligibility decision. It also includes a system review, including checking SVES, SDX, BENDEX, and reviewing all screens in MEDS or MEDSX and updating the information as needed.

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101.11.02 ASSIGNMENT OF REVIEW DUE DATES

A regular review must be completed on each recipient at intervals not to exceed 12 months. Both MEDS and MEDSX automatically set a 12-month review at application and redetermination as follows:

- In MEDS, the review due date is set 12 months from the month in which the supervisor authorizes the application or redetermination action.
- At application, MEDSX sets the CHIP review due date 12 months from the CHIP effective month. The Medicaid review due date is set 12 months from the application month.

When the 12-month eligibility period is set by the system, retroactive Medicaid months are not included in the 12-month count. Refer to the FCC program section for instructions for authorizing the continuous eligibility when a child is eligible only in a retroactive month(s).

At review MEDSX sets the review due date 12 months from the from the time span begin date on the Time Period Selection screen for both Medicaid and CHIP.

The reviewing supervisor is responsible for ensuring the proper review due date is assigned to each individual and for correcting or adjusting system-assigned dates at authorization when needed.

While children are assigned a 12-month review, adults may be reviewed more frequently based on case circumstances and the likelihood of changes. However, no individual's review due date may be adjusted to exceed 12 months.

101.11.03 TIMELY PROCESSING

It is important for redeterminations to be completed in a timely manner to prevent overdue cases. Since a recipient's eligibility does not expire, benefits continue until the agency completes the review and an eligibility decision is made to either approve or terminate coverage. A review becomes overdue when more than 12 months have passed since the last eligibility determination. It is the responsibility of regional office staff to ensure reviews are processed timely.

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When to Begin Processing a Review

It is permissible to begin the review process as early as the 10th month of a 12-month eligibility period or no more than 2 months early. However to ensure timeliness, the review process must begin no later than the month prior to the review month. This means for a case with a review due date of August, the redetermination process may begin as early as June, but must begin no later than July.

101.11.04 TIMELY AUTHORIZATION

The approval of a Medicaid redetermination is timely if it is authorized by the last day of the month in which the review is due. If Medicaid benefits are terminated, the action must be authorized no later than the adverse action deadline in the review month to be effective the following month. A CHIP approval is timely if it is authorized by the CHIP deadline in the month in which the review is due. A CHIP termination must be authorized no later than the adverse action deadline in the review month to be effective the following month.

When a redetermination closure is not authorized by the adverse action deadline in the review month, the case or individual is out of certification. However, an improper payment report is not required for the untimely closure. Ineligibility must exist for another reason for an improper payment report to be prepared.

Adverse Action Deadlines

In MEDS, the adverse action deadline is 12 days from the end of the month. Action must be taken by the adverse action deadline in the review month if coverage is to be terminated at the end of the review month.

In MEDSX if the Medicaid or CHIP termination action is authorized by the 19th of the month in which the review is due, the termination is effective at the end of the review month. An exception is February when the adverse action deadline in MEDSX is the 17th.

NOTE: Adults are not guaranteed 12 months of coverage. If termination is appropriate, the specialist will take action to terminate an adult's eligibility for the earliest possible month. However, coverage must be terminated no later than the adverse action deadline in the last month of the review period for the redetermination closure to be timely.

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101.11.05 EXPARTE REVIEWS

Any recipient under review who is losing eligibility in one category of assistance is entitled to have eligibility reviewed and evaluated under any/all available coverage groups. The term “exparte review” means to review information available to the agency to make a determination of eligibility in another coverage group without requiring the individual to come into the office or file a separate application.

When to Complete an Exparte Determination

For an exparte determination to be made, the specialist must be in the process of making a decision on a current application, review or reported change. If the specialist is denying or closing for failure to return information or failure to complete the review process, an exparte determination is not applicable.

Example: Jane Doe’s CHIP eligibility will terminate because the family reports she is now covered under other health insurance. The specialist must review the record to see if it contains information which indicates the child has potential eligibility under another coverage group.

Example: Recipient Tom Smith failed to comply with the annual review requirement and his eligibility must be terminated. The specialist does not complete an exparte determination.

Basis for the Exparte Review

The decision of whether the recipient is eligible under a different coverage group must be based on information contained in the case record. This may include income, household or personal information in the physical record which indicates the ineligible adult or child has potential eligibility in another coverage group. However, information received through electronic matches with other state/federal agencies such as a disability onset date or prior receipt of benefits based on disability are also part of the case record.

Obtaining Information to Make the Determination

When potential eligibility under another coverage group is indicated, but the specialist does not have sufficient information to make an eligibility determination, the recipient must be allowed a reasonable opportunity to provide necessary information.

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Obtaining Information to Make the Determination (Continued)

Using DOM-307, the specialist will ask the recipient to provide verifications needed to determine eligibility in the new category. If the individual is an ABD recipient potentially eligible in an FCC category or vice versa, the request will include completion of the appropriate application form to collect required program information. An in-person interview is not conducted in the exparte review process even for a program that normally requires an interview.

Eligibility Decision

If the individual is subsequently determined to be eligible in the new category, the approval must be coordinated with termination in the current program to ensure there is no lapse or duplication in coverage. However, if requested information is not provided or if the information clearly shows that the recipient is not eligible under another category, eligibility in the current program will be terminated with advance notice.

During the advance notice period, the recipient is allowed time to provide all requested information to determine eligibility in the new program, provide information which alters the decision to terminate benefits in the current program or request a hearing with continued benefits. The specialist must take prompt and appropriate action to reinstate benefits when the recipient either provides all requested information needed to determine eligibility in another category, provides information which changes the termination decision in the current program, or requests a hearing with continued benefits during the advance notice period.

NOTE: When the recipient is determined ineligible in the new category, he does not have to repay the benefits he received while the eligibility determination was in process. However, if benefits are continued pending a fair hearing decision and the outcome is not favorable to the recipient, he is liable for repayment of the cost of services furnished solely because of the continuation of benefit provision.

Requested Information Provided After Closure

If the recipient subsequently provides all of the information needed to assess eligibility in the new program within 2 months of termination, the case should be handled in accordance with the procedures discussed in sections 101.11.07E and 101.11.08I.

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EXPARTE REVIEWS (Continued)

Example: A CHIP review is due in May. On May 10th, the specialist determines the children’s eligibility will terminate because of excess family income. She completes an exparte review of the case record and notes the SVES response for one child indicates the child has prior SSI eligibility. Since information available to the agency indicates a potential disability for this child, the specialist determines the child must be evaluated for another coverage group before her CHIP eligibility can be terminated. Since the exparte review does not indicate potential eligibility in any other coverage group for the other children, the specialist completes the closure action for them, leaving eligibility open for the potentially eligible child. She documents the case to support the action .

The specialist issues a 307 requesting a completed ABD application form and other information to determine Medicaid eligibility based on disability. The family does not respond to the request. On May 23rd after the 307 request period has expired, a 309, Second Request for Information, is issued. The family subsequently provides the required information. CHIP benefits remain open while the eligibility determination process continues.

On August 18th, the child is determined eligible in the Disabled Child Living at Home program. Her CHIP eligibility is terminated in MEDSX effective August 31st and Medicaid eligibility is authorized effective September 1st in MEDS.

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❖ Aged, Blind and Disabled Programs

101.11.05A SSI REDETERMINATIONS

The SSI redetermination process is a type of exparte review. When individuals are terminated from SSI due to income and/or resources, they are issued an SSI Termination Notice and an SSI Redetermination Form, DOM-300B, by the fiscal agent upon receipt of SDX notification of termination. This form is to be completed and returned to the appropriate regional office if the recipient wants to apply for continued Medicaid coverage and is eligible under one of the coverage groups described in the SSI Termination Notice.

An in-person interview is not conducted, even if the program is one that normally requires an interview. However, all necessary factors of eligibility must be verified, such as disability, residency, utilization of benefits, etc. In addition, if other health insurance coverage is indicated on the 300B, TPL information must also be obtained.

SSI redeterminations have a 30-day processing standard, unless a DDS determination must be obtained.

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101.11.06 METHODS FOR CONDUCTING A REGULAR REVIEW

Depending on the case type, the following methods are used to obtain a completed application form and other information needed to process a regular redetermination:

- **In-Person Redetermination** - When an in-person interview is required or requested, one will be conducted. If an appointment is needed, the specialist will issue the appointment via DOM-307, Request for Information, and include any information which is known to be needed on the request notice.

This includes situations in which a recipient or representative comes to a more conveniently located regional office or out-station location to complete the redetermination on a case assigned to a different office.

- **Mail-In Redetermination** - For cases where a mail-in redetermination is permissible, the specialist will attach the application form to the DOM-307, include a request for any information which is known to be needed and mail it to recipient to complete and return.
- **Telephone Redetermination** – For cases where this is an option, the specialist may conduct a telephone interview and complete the application form based on the information provided by the recipient. A DOM-307 will be issued with the completed application attached for the recipient's review and signature. The request will also confirm other information which has to be provided by the recipient to complete the redetermination.

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101.11.07 REGULAR REDETERMINATION PROCESS

❖ Aged, Blind and Disabled Programs

101.11.07A REDETERMINATION REPORTS

The Monthly MEDS Redetermination Due Listing (RJ076), sorted by regional office and caseload, identifies cases due and coming due for redetermination for a 3-month period. The report also lists any cases which are overdue as of the report date.

On a monthly basis, specialists will identify the cases assigned to them which are coming due for redetermination and begin the process to complete the application form and obtain any additional information needed for the review. As reviews are completed during the month, the specialist can use the RJ076W, Weekly MEDS Redetermination Due Listing, to identify cases which are still pending.

101.11.07B REQUESTING INFORMATION

Information is requested via DOM-307, Request for Information. If new or additional information, not included on the initial 307 is subsequently identified, another DOM-307 must be issued to request the information for the first time.

DOM-309, Second Request for Information, will be issued for any information requested via DOM-307(s) which is not submitted by the due date.

101.11.07C FOLLOW-UP CONTACT

When the client fails to provide all needed information, action cannot be taken to terminate ABD benefits due to failure to provide information without first attempting a telephone contact to inform the client of the information needed and when it must be provided to prevent termination due to non-receipt.

In addition, the recipient must also be informed that the case may be reinstated if all information is provided within the advance notice period and that a new application will not be required if the information is provided within 2 months of termination.

All efforts to contact the client must be documented in the case.

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101.11.07D DISPOSITION

❖ Aged, Blind and Disabled Programs

Approval of Continued Benefits

When the client has complied with all redetermination requirements and provides required verifications, the specialist will review the eligibility criteria; ensure appropriate documentation is filed in the case record and input the data into MEDS for an eligibility decision. All redeterminations are submitted for supervisory review and authorization. When eligibility will continue at the same level, a new review due date is established and an approval notice issued to the recipient when benefits are authorized.

Reduction or Termination of Benefits

Advance notice of adverse action is required, if the eligibility decision results in

- Termination of benefits;
- Conversion to a reduced services coverage group;
- Increase in the amount of patient liability
- Termination of a nursing facility vendor payment.

During the advance notice period, the recipient is allowed time to fully comply with unmet redetermination requirements, provide information or verification that will alter the decision to terminate or reduce benefits, or request a Fair Hearing with continued benefits.

MEDS is not programmed for the case to remain open during the adverse action period; however, eligibility staff must treat the case as if it is open until the period has ended. During this period if the client subsequently complies with all redetermination requirements or provides information which changes the negative action, eligibility must be re-processed. If the client requests a hearing, with continued benefits, the case must be promptly reinstated.

Specialists must take prompt action on the information provided during the advance notice period. Timely action must be taken to prevent a break in coverage, whether the client takes action within the first few days of the adverse action period or on the final day.

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Reduction or Termination of Benefits (Continued)

Example: The recipient did not provide income verification needed for the May redetermination. The closure is authorized on May 10th and advance notice is mailed to the client advising that eligibility will terminate effective May 31st. On May 18th, within the advance notice period, the verification is received in the office. The specialist takes action to process the case as a reinstatement and determines eligibility using the current income. The supervisor then reviews the action and authorizes the eligibility decision. Appropriate notice is issued to the client and there is no break in coverage.

101.11.07E COMPLIANCE AFTER CLOSURE

When the ABD client fully complies with redetermination requirements after closure, a reapplication is not required if the following is met:

- The case has been closed for 2 months or less at the time of full compliance.

Example: The ABD recipient did not comply with review requirements for a May redetermination. The closure is authorized on May 10th effective May 31st. If the client fully complies by July 31st, eligibility can be determined using the reinstatement process. After July 31st, a reapplication must be filed.

The specialist is responsible for taking action within 48 hours of full compliance to register the reinstatement in MEDS. If the reason for closure is failure to provide requested information, the case will be processed using the most recently completed application form. There is no requirement to re-interview the recipient, if applicable, or obtain an updated signature on the application form. If redetermination requirements are not fully met during the 2-month timeframe, a reapplication is required.

Partial Compliance After Closure

If the recipient partially complies with redetermination requirements after case closure, a telephone contact will be attempted to inform the recipient of the action or information still needed. All efforts to contact the client must be documented in the case.

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101.11.08 REGULAR REDETERMINATION PROCESS

❖ Families, Children and CHIP Programs

101.11.08A FREQUENCY OF REVIEWS

A full review must be conducted for all FCC case members in the situations discussed below:

- At the earliest 12-month review when case members have different review due dates;

When a redetermination is currently due for some, but not all case members, the annual redetermination will be completed on everyone to attempt to align redetermination dates for the following year and assure one annual review for the family.

- When an application is filed to add a new biological/legal child or legal parent to the case;

In this instance, the specialist will enter an application contact in MEDSX for the applicant(s) and a redetermination contact for other case members to process eligibility on everyone.

NOTE: If the HOH complies with redetermination requirements, but has had insufficient time to receive the appropriate documents to verify enumeration for a deemed eligible newborn, a review will be completed for children who are currently due. The deemed eligible baby will then be reviewed at his assigned review date.

101.11.08B PROCESSING CHILDREN CURRENTLY DUE FOR REVIEW

If a child, currently due for review, is determined ineligible or will have a program change from Medicaid to CHIP or vice versa, the action must be effective at the end of the current 12 month review period. To process the termination or change in MEDSX, the specialist will enter the month following the child's review due month as the time span begin date.

Example: The child's review due date is May. The time span begin date is set for June. If timely action is taken by the adverse action deadline in May, a termination will be effective May 31st. If a program change is involved in this example, action must be taken by the CHIP deadline in May for the program change to be effective June 1.

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101.11.08C PROCESSING CHILDREN NOT CURRENTLY DUE FOR REVIEW

Each FCC child must be provided 12 months of continuous eligibility in his eligible category. Prior to the end of the 12-month period, a child cannot be:

- Terminated, unless an early termination reason exists, or
- Changed from one program to another (Medicaid to CHIP or vice versa) unless the HOH voluntarily requests early closure in the current program or the original determination was in error.

Termination

When the family's redetermination results in ineligibility for a child with a review due date in the future, the child's termination must be effective at the end of his 12 months of continuous coverage.

Example: May is the earliest review date for the case; however, one child is not due until August. To process a termination, this child's time span begin date is set for September, while the span for the other children is set for June. If timely action is taken by the adverse action deadline in May, the children due for review in May will be terminated effective May 31. The child due for review in August will terminate effective August 31.

Program Change

When a program change is involved for a child with a future review date, the change cannot be made until the end of the child's current eligibility period unless the HOH voluntarily requests early termination in the current program. This request must be made in writing via the Request to Close Prior to End of 12 Months form or other written statement requesting early closure and signed by the HOH.

Example: May is the earliest review date for the case; however, one child's review date is August. If a program change from Medicaid to CHIP results, this child will continue to be Medicaid-eligible through August with CHIP coverage effective September 1st unless the HOH requests early Medicaid termination. If the HOH does request early Medicaid termination, the time spans of all the children will be set for June and the case processed for CHIP effective June 1. If the HOH does not request early termination, the time span begin date of the child due in August will be set for September and he will move to CHIP September 1 while his siblings go to CHIP June 1.

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Program Change (Continued)

The Request to Close Prior to End of 12 Months form is not necessary if all children in the case are currently due for review; therefore, the form must not be completed on a wholesale basis on every case. As the above example indicates, the form should be discussed with the HOH to facilitate an early program change for a child with a future date to place the child in the same program as siblings and align review due dates for the family's convenience. If the form is not completed, the child with the future review date will move to his new program at the end of his current eligibility period.

Processing an Application and a Review

As previously indicated, when an application is filed to add a new biological/legal child or a legal parent applying for 85 or pregnant woman applying in 88 to an active case, a review is completed for existing case members at the same time the application for the new member is processed as the following examples illustrate:

Addition of Legal Parent to Active Case for 85 Eligibility

Example: The children are active in CHIP; however, their mother lost her job and files an application including a request for herself on May 1st. An application contact is set for the adult and a redetermination contact is set for the children. The mother's time period begin date is May ongoing. The children's time period begin date is set for July, the next possible month a change can be made in CHIP eligibility. The family is subsequently determined to be eligible for 85 and the approval is authorized on May 20th. The mother is approved in 85 beginning May. The program change to 85 for the children is effective July.

Example: The children are active in g1 Medicaid; however, their mother lost her job and files an application including a request for herself on May 1st. An application contact is set for the adult and a redetermination contact is set for the children. The time period begin dates for the mother and children are set for May ongoing. The family is subsequently determined to be eligible for 85 and the approval is authorized on May 20th. The 85 effective date for mother and children is May.

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Addition of Pregnant Woman to Active Case for 88 Eligibility

A pregnant woman can elect to include or exclude children from her application. If her children already have active coverage in Medicaid or CHIP at the time she files her application, the children must be included in the 88 eligibility determination and a review must be completed for them at the same time the mother's application is processed. The following example illustrates:

Example: The children are active in CHIP with a review due in September; however, their mother files an application in May as a pregnant woman. An application contact is set for the mother and a redetermination contact is set for the children. The mother's time period begin date is May ongoing. The children will be eligible in 87 Medicaid based on current income and the increased need standard. The mother does not want CHIP eligibility to be terminated early and does not sign the closure request form. The children's time period begin date is set for October. Eligibility is authorized on May 20th as follows: 88 Medicaid for the mother beginning May and 87 Medicaid for the children effective October.

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101.11.08D ASSIGNMENT OF REVIEW DUE DATES

Setting the correct time span at review is important for FCC cases to ensure 12 months of continuous eligibility is provided for children. MEDSX sets the review due date from the time span begin date on the Time Period Selection Screen. When completing an FCC review, the specialist should set time spans in MEDSX as follows:

- **Overdue for Review** - Set the time span for the month following the month of the interview. Children who are approved will have a new review due date 12 months from the time period begin month. Ineligible children will be terminated by the adverse action deadline for the next possible month.

Also refer to 101.11.08C above for instructions on handling children in an overdue case who have future review due dates.

- **Current Reviews** - Set the time span for the month following the earliest redetermination due date for the case. This is the starting point to begin the eligibility assessment. If all children are approved again in the same program, the new review dates will be 12 months from the time period begin month.

However, if a program change or termination results for children with a future review date, it will be necessary to adjust the time spans of those children to allow them 12 months of continuous coverage. Also refer to 101.11.08C above.

- **Early Reviews** - Begin the time span with the month following the earliest redetermination due month for the case. This is the starting point to begin the eligibility assessment. If all children are approved again in the same program, the new review dates will be 12 months from the time period begin month.

If a program change or termination results, it will be necessary to adjust the time spans of children with future review dates to allow 12 months of continuous coverage prior to termination or program change. Also refer to 101.11.08C above.

When caseload adjustments are needed to equalize the number of reviews due the following year, it is also permissible to set the time span for an early review to begin the month following the month of the interview. The case should be documented when this action is being taken. Instructions at 101.11.08C must be followed for children with future review due dates.

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ASSIGNMENT OF REVIEW DUE DATES (Continued)

If termination or a program change is involved for a child with a future review date whether the case has other members who are currently due, overdue or being completed early, the time spans must be adjusted to ensure the child receives 12 months of continuous coverage prior to the effective date of termination (unless there is an early termination reason) or program change..

A change from Medicaid to CHIP and vice versa does not require advance notice; however, the issue of continuous eligibility must be properly addressed prior to a program change and the change must be authorized by the CHIP deadline to be effective the following month.

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101.11.08E NOTICE OF UPCOMING REVIEW

A system-generated Notice of Upcoming Review is issued to FCC Heads of Household two months prior to the earliest review due date for the case. This notice informs the family of the impending review and provides general information which will be needed to complete the redetermination process.

101.11.08F REDETERMINATION REPORTS

The Monthly MEDSX Redetermination Due Listing (RJ431), sorted by regional office and caseload, identifies the cases due and coming due for redetermination for a 3-month period. The report also lists any cases which are overdue as of the report date.

On a monthly basis, each specialist will identify cases subject to redetermination and begin the redetermination process to complete the application form and obtain additional information to complete the review. As reviews are completed during the month, the specialist can use the RJ431W, Weekly MEDSX Redetermination Due Listing, to identify cases which are still pending.

101.11.08G SCHEDULING THE INTERVIEW AND REQUESTING INFORMATION

The specialist will issue an interview appointment via DOM-307, Request for Information. FCC review appointments must be scheduled to allow a minimum of 14 days between the appointment notice and the date of interview. Information known to be needed will also be requested on this 307. In this instance, the information due date is the day of the interview.

If additional information is determined to be needed at the interview or the client requests additional time to provide some or all of the previously requested information, a second DOM-307 will be issued.

101.11.08H DISPOSITION

Approval of Continued Benefits

When the head of household complies with redetermination requirements and provides required verifications, the specialist will review all eligibility criteria, ensure appropriate documentation is filed in the case record and input the data into MEDSX for an eligibility decision on the case members.

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Approval of Continued Benefits (Continued)

All redeterminations are submitted for supervisory review and authorization. When eligibility will continue, a new review due date is established based on the time span set for each individual and an approval notice is issued to the HOH.

Termination of Benefits

Advance notice of adverse action is required, if the eligibility decision results in termination of benefits for all or some members of the case. During the adverse action period, the head of household is allowed time to fully comply with unmet redetermination requirements, provide information or verification that will alter the adverse action decision or request a Fair Hearing with continued benefits.

MEDSX is not programmed for the case to remain open during the adverse action period; however, eligibility staff must treat the case as if it is open until the adverse action period has ended. If the client subsequently complies with all redetermination requirements, provides information which changes the negative action or requests a Fair Hearing within the advance notice period, eligibility must be reinstated to prevent a loss of benefits.

In MEDSX, there is no reinstatement function, an application contact is required for any person with a status of denied ongoing. Otherwise, a notice will not be generated. Prompt action must be taken to prevent a break in coverage, whether the client takes action within the first few days of the adverse action period or on the final day. This is applicable for FCC Medicaid programs and CHIP.

Preventing a break in coverage is accomplished more easily in Medicaid than CHIP due to the CHIP processing deadline. When the CHIP client fully complies within the adverse action period and before the CHIP deadline, action must be taken to reverse the termination and ensure benefits are authorized for the following month with no break in coverage.

When the client complies after the CHIP deadline, but still within the adverse action period, eligibility must be re-established for the next possible month. CHIP agency error procedures should be followed for months of lost benefits.

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Termination of Benefits (Continued)

If the FCC head of household is subsequently interviewed within the adverse action period, but fails to provide requested information during this timeframe, application rules apply. An eligibility decision must be made within the 30 days.

Example: The head of household failed to meet the interview requirement for a May redetermination. The case was closed on May 19th effective May 31st. On May 29th the interview requirement is met; however, information needed to process the case is not provided. An application contact is registered for May 29th. A 307 is issued for the information and 30-day processing is applicable.

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101.11.08I REQUESTED INFORMATION PROVIDED AFTER CLOSURE

After closure, a new application form is not required to determine eligibility for the case or an individual if the following requirements are met:

- The head of household subsequently provides all information needed to complete the redetermination; **and**
- The case has been closed for 2 months or less at the time the information is provided based on the earliest termination date for the case; **or**
- For an individual who was currently due for review, the individual has been terminated for 2 months or less at the time the information is provided;

or

- If the only child who is terminated has a future date, the information is provided within 2 months of the month in which the action was taken to terminate eligibility.

The following example illustrates:

Example: Three children in the case are due for May review and one child is due in August. The head of household failed to verify income. On May 10th action was taken to terminate eligibility effective May 31st and August 31st, respectively. The income verification must be provided by July 31st based on the earlier effective date for the case.

If the child with the future termination date of August 31 was the only child in this case who was terminated on May 10th, the information which caused the child's termination must be provided no later than July 31st within 2 months of May, the month in which the termination action was taken.

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❖ Families, Children and CHIP Programs

REQUESTED INFORMATION PROVIDED AFTER CLOSURE (Continued)

There is no requirement to re-interview the head of household or obtain an updated signature on the application form. The specialist is responsible for registering the case within 48 hours of receipt of the information. As previously indicated, there is no reinstatement function in MEDSX, an application contact is required to determine eligibility and issue proper notification for any person with a status of denied ongoing. If all requested information is not provided during this 2-month timeframe, a reapplication must be filed.

Incomplete Information Provided After Closure

If only part of the information is provided, a telephone contact will be attempted to inform the recipient of the information which is still needed. All efforts to contact the client must be documented in the case.

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101.12 SPECIAL REVIEWS

A special case review is completed when changes occur between regular reviews, which may result in adjustments to eligibility or benefit level. A special case review is not a full review. Instead the case (or an individual) is evaluated to consider the impact of the changed information. Factors unrelated to the change are not re-verified as part of a special review.

Example: An 85 adult recipient reports three months after her regular redetermination that she has a part-time job. The children in the case have income from child support which was last verified at the regular review. The child support income is not subject to re-verification since it is not part of the reported change.

A special review of eligibility is required when:

- The recipient reports a change in circumstances which could affect eligibility and benefit level;
- Information is received from any other source which could affect eligibility and benefit level;
- Potential changes in eligibility are indicated by information available to the agency.

The special review process may result in termination of benefits, benefit reduction or adjustments to Medicaid Income. It may also involve procedural changes, i.e., updating or correcting case information with no impact on eligibility or benefits. Procedural changes may include:

- Name corrections or changes;
- In-state address corrections or changes;
- Change or appointment of a guardian or conservator;
- Case transfers between regional offices;
- Program transfers such as a disabled or blind recipient turns age 65, becoming an aged client.

NOTE: In MEDSX, name, address, SSN, race and gender can be changed or corrected on a processed time span. However, eligibility must be re-processed to correct the date of birth in MEDSX. A special contact and time span are required to re-process eligibility in MEDS to change or correct demographic information.

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101.12.01 RECIPIENT REPORTING REQUIREMENTS

Recipients must report required changes within ten days of the date the change becomes known. Changes may be reported in person, by telephone or by mail. A change is considered reported on the date the report of change is received by the agency. If an individual fails to report timely or the agency fails to take timely action, causing the recipient to receive benefits to which he is not entitled, the specialist will take steps to report an overpayment.

101.12.01A CHANGE REPORTING REQUIREMENTS

❖ **Aged, Blind and Disabled Programs**

The following types of changes must be reported by ABD recipients within 10 days of the date the change becomes known:

- Changes in address in or out of state;
- Changes in marital status;
- Changes in income for the recipient and/or spouse;
- Change in any type of policy that would pay for medical services, such as health insurance, indemnity policies, major medical policies, CHAMPUS or legal settlements;
- Changes in a recipient's disability which would affect his Medicaid eligibility;
- Changes in living arrangements, such as a long term care (LTC) recipient entering a hospital or a nursing home, leaving a hospital or a nursing home, moving from one medical facility to another;
- Changes in resources, i.e., recipient buys, sells, gives away or receives an asset or any part of an asset; and.
- Changes in health insurance premiums for LTC recipients.

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101.12.01B CHANGE REPORTING REQUIREMENTS

❖ Families, Children and CHIP Programs

The following changes must be reported by FCC recipients within 10 days of the date the change becomes known.

All FCC Recipients

- Changes in address in or out of state;
- Changes in any type of policy that would pay for medical services, such as health insurance, indemnity policies, major medical policies, CHAMPUS or legal settlements.

85 Adults

- Increases in earnings or other income;
- Changes in marital status;
- Changes in household, such as spouse or parent entering or leaving the home and/or children entering or leaving the home.

85 Adults on Extended Medicaid

- Termination of employment when new or increased wages caused ineligibility;
- Termination of child support income when new or increased child support caused ineligibility.

Pregnant Women

- Change in the verified due date, i.e., earlier delivery/termination date or later due date than originally verified.

Child Only Cases

- Children leaving the home (includes institutionalization, death, foster care, etc.);
- Uninsured CHIP child becoming covered by creditable health insurance;
- CHIP child becoming pregnant.

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101.12.02 TAKING ACTION ON REPORTED CHANGES

Specialists must follow up on information which is reported by the recipient or otherwise becomes known to the agency to determine if the information is a reportable change. If the change is not reportable, the information will be considered at the next regular review. For instance, an income increase reported by the parent of a CHIP child is not a reportable change because of the continuous eligibility provision for children in FCC. The impact of an increase in parental income will be considered at the next review. However, if the parent reports the CHIP child has moved from the state that is a reportable change which must be acted upon.

Action on a reportable change must be initiated no later than 10 working days from the date the change becomes known to the agency to determine its impact on eligibility and benefit level.

NOTE: It is imperative that timely action be taken on reported changes to prevent agency error. For instance, recipients frequently report address changes. Failure to take prompt action on these changes not only results in inconvenience to the recipient, but also may lead to benefits being terminated in error when notices are mailed to the wrong address. .

If verification of a reportable change is needed from the recipient, DOM-307 will be issued to provide written notice of the required information and due date. DOM-309 will be issued, when applicable, to ABD recipients. If the client fails to respond to the 307 or 307/309 requests, eligibility will be terminated allowing 10-day advance notice.

Documenting the Case Record

The case record/case narrative must reflect the following information about the reported change:

- Who reported the change;
- When the change was reported;
- How the change was reported;
- When action was initiated on the change;
- What was used to verify the change; and
- What action was taken in regard to the verified information.

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101.13 NOTIFICATION

The recipient and, when applicable, the medical facility must be notified in writing of the action taken on an application or an active case when eligibility or benefit level is affected by a change. Notices are generated by the MEDS and MEDSX systems based on the type of contact and the results of the eligibility determination.

NOTE: It is the specialist's responsibility to review and if needed correct notices printed in the regional office before they are mailed to the recipient.

If a manual notice is required for the recipient, refer to instructions for the DOM-305, Notice of Action, or DOM-306, Notice of Adverse Action. When a manual notice must be issued to a facility, DOM-317, Exchange of Information Between Nursing Home or Hospital and Medicaid Regional Office, is used.

101.13.01 ADVANCE NOTICE

Federal regulations require issuance of a notice of adverse action 10 days before the effective date of an action to reduce or terminate benefits. In MEDS, the adverse action deadline is 12 days from the end of the month. In MEDSX it is the 19th of each month except February when the deadline is the 17th.

During the advance notice period, the recipient is allowed time to fully comply with unmet requirements, provide information or verification that will alter the decision to terminate or reduce benefits, or request a Fair Hearing with continued benefits. If this occurs, the agency must take prompt and appropriate action to reinstate benefits.

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101.13.02 EXCEPTIONS TO ADVANCE NOTICE

Unless noted, the following actions require notification to the recipient; however, 10-day advance notice is not required.

Death

When the agency has factual information verifying the death of a recipient, the date of death and verification source must be recorded in the record. A notice is not generated by either system if the termination reason is death.

Some acceptable sources to verify the death date are:

- SVES or SDX;
- Report from recipient's representative or the FCC Head of Household;
- Viewing the death certificate,
- Contact with the funeral home or the attending physician;
- Contact with the hospital or nursing home where the patient died;
- Dated newspaper clippings;

Loss of State Residence

When the agency establishes that a recipient has moved from the state through information received from the recipient or because another state reports the client has been accepted as a resident for Medicaid in that state, advance notice of closure is not required.

Resident of a Public Institution

When the agency has established that the recipient has been admitted to a public institution, such as a prison or a state hospital in a non-Title XIX facility, advance notice of termination is not required.

Unable to Locate

When a recipient's whereabouts are unknown, the agency must take reasonable efforts to locate the recipient. When agency mail is returned by the post office with no forwarding address and other efforts to locate the recipient are unsuccessful, eligibility will be terminated. However, if the client's whereabouts subsequently become known during the time the client is eligible for services, the case must be reinstated. Refer to 101.14 for a discussion of the reinstatement process.

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EXCEPTIONS TO ADVANCE NOTICE (Continued)

Voluntary Request for Closure

If the recipient or his designated representative voluntarily requests closure, advance notice is not required. If the request is made in person, the specialist will obtain the request in writing. Otherwise, the specialist will document the case to reflect the specifics of the request.

Eligible for Medicaid through Another Source

If an FCC or ABD recipient becomes Medicaid-eligible through SSI or foster care, advance notice of termination of benefits authorized through the Medicaid Regional Office is not required.

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101.14 REINSTATEMENTS

Certain situations require a reinstatement of services, which means either eligibility is restored or Medicaid income is corrected for a prior period. Both types of reinstatements are completed without requiring that a new application be filed on behalf of the recipient. A reinstatement is in order in the following situations, as applicable, to ABD and FCC recipients.

NOTE: There is no reinstatement function in MEDSX. If a reinstatement of benefits is required for an FCC recipient, an application contact must be used. Information will be provided in the comments section of the notice to explain the action being taken to the recipient.

Hearing Decision

When a decision, granting eligibility or increased benefits is rendered as a result of a state or local hearing, the regional office may be required to reinstate eligibility or when appropriate correct Medicaid Income, retroactive to the date decided by the hearing official. If benefits were continued in an active case pending the hearing decision, reinstatement may not be required unless the decision at the hearing is to increase the level of benefits in effect prior to the hearing.

Advance Notice Period

When the client makes a timely hearing request during the advance notice period, benefits will be continued at the same level through the reinstatement process until a hearing decision is reached.

If the recipient provides information that changes the adverse action decision or fully complies with unmet requirements during the adverse action period, benefits must be reinstated to ensure no loss of benefits, if the recipient remains eligible.

If advance notice of benefit reduction or termination is not issued as required, benefits must be reinstated at the time the error is discovered, regardless of whether the client is currently eligible. After benefits are reinstated, advance notice would be issued.

NOTE: Medicaid benefits must be reinstated to ensure there is no loss of benefits. CHIP benefits must be reinstated for the next possible month. If the child incurred medical services in any lost CHIP months, handle through the CHIP agency error process.

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REINSTATEMENTS (Continued)

Whereabouts Unknown

As indicated previously, eligibility must be terminated if a client's whereabouts remain unknown after the agency has (1) received returned mail with no forwarding address and (2) made reasonable efforts to locate the recipient. If the client's location subsequently becomes known during the time he is eligible, benefits will be reinstated.

For a child who has continuous eligibility, Medicaid benefits must be reinstated with no loss. CHIP benefits must be reinstated for the next possible month. If the child incurred medical services in any lost CHIP months, handle in the same manner as CHIP agency errors. For an adult, the specialist must determine eligibility for each month that the adult recipient's whereabouts were unknown and reinstate for any period he would have been eligible.

Temporary Case Closure

When it is known that a client will be ineligible for two months or less, the closure is processed in the usual manner; however, at the end of the temporary period, the case may be reinstated without completing new eligibility forms necessary for reapplication. The case record will show:

- The exact length of time during which ineligibility will exist;
- The date the recipient will be eligible again;
- The reason for the temporary ineligibility.

In this situation a break in eligibility correctly exists; therefore, it is necessary to adjust the eligibility begin date to reflect the most recent eligibility begin date.

Reapplication

When an applicant has a prior application which has been in rejected status for 2 months or less, the rejected application form can be updated and signed by the applicant or representative to establish a new application date. Factors of eligibility which are not subject to change do not have to be re-verified. Income and, if applicable, resources may have to be re-verified, depending on the new application file date, the type of benefit, whether any changes are reported by the applicant, etc. The eligibility begin date is controlled by the second or updated application date.

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REINSTATEMENTS (Continued)

Agency Error

When the agency has denied or terminated eligibility in error or reduced benefits in error for reasons such as failure to act on information present in the record or provided during the advance notice period, misapplication of policy, miscalculation of income or resources, untimely processing, etc., benefits must be reinstated retroactive to the month the error occurred, when this is possible. If CHIP is involved, the reinstatement must be effective for the next possible month. If the child incurred medical services in any lost CHIP months, this would be handled through the CHIP agency error process.

The discovery source for the error may be:

- Case reviews;
- Applicant or recipient complaints;
- Recognition by the specialist;
- Other sources having knowledge of the error.

101.14.01 CORRECTIVE ACTION

At the time the agency becomes aware of an error which affects eligibility or level of benefits, action must be initiated to correct the error. Immediate corrective action is required to prevent further error. In some instances, it may also be necessary to correct an error retroactively into prior months.

When corrective action into prior months adversely affects the recipient, meaning the error caused the client to be totally ineligible or eligible for fewer benefits, DOM-354, Improper Payment Report, or DOM FCC-354, Improper Payment Report Families, Children and CHIP, is prepared.

When corrective action into prior months favorably affects the client, meaning the client was eligible or eligible for more benefits, the corrective action is handled through reinstatement.

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101.15 OTHER CHANGES

❖ Aged, Blind and Disabled Programs

101.15.01 CHANGES IN MEDICAID INCOME

The amount of income an institutional client must pay to the nursing facility toward the cost of his care is known as Medicaid Income. Changes in income, marital status or non-covered medical expenses will either increase or decrease Medicaid income. The effective dates of such changes are determined as follows:

Decrease in Medicaid Income

A change which results in a decrease in Income is effective the month in which the change is reported or becomes known to the agency. For example, a decrease in income reported any time in the month of June will be effective as of June 1. The notice issued to the client and to the facility will specify June 1.

Increase in Medicaid Income

A change which results in an increase in Medicaid Income requires advance notice to the client advising of the increase. However, advance notice for Medicaid Income increases is based on issuing notice 10 days before the date Medicaid makes its payment to the facility.

A nursing home cannot submit a claim for any month's payment until the first day of the following month. Payment is then made to the facility on the first Monday following receipt of the claim. This means the specialist has 10 days before Medicaid makes its payment to a facility to increase Medicaid Income for the current month. Since payment schedules may vary, policy governing increasing Medicaid Income in the current month is based on whether advance notice can be issued 10 calendar days before the first of the following month.

Example: An increase in a recipient's income is discovered on October 10, Medicaid Income can be increased effective October 1 if advance notice of the increase is issued no later than October 21.

NOTE: If a state or local hearing is requested within the advance notice period, the increase cannot be effective until the final hearing decision is rendered.

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CHANGES IN MEDICAID INCOME (Continued)

Temporary Decrease in Medicaid Income

When Medicaid Income is temporarily decreased due to the allowance of a deduction, i.e., health insurance premium or other non-covered medical expense, and Medicaid Income is subsequently returned to the amount previously in effect, this action is not considered an increase in Medicaid Income subject to advance notice.

When the client is notified of the allowance of the deduction, the notice should also advise that Medicaid Income will return to the previous amount and specify the amount and date Medicaid income will resume.

In any instance where Medicaid Income does not revert back to the amount in effect prior to allowance of a deduction, an increase would require advance notice.

Increase in Medicaid Income Combined with a Closure

In instances where income is counted in the month received, but receipt of the income also renders the client ineligible, the excess income is included in the Medicaid Income computation provided there are 10 calendar days left in the month of receipt to allow for advance notice. In addition to increasing Medicaid Income for the month of receipt, the case is also scheduled for closure.

Example: A client receives a lump sum VA payment of \$4000 in December which is reported to the regional office on December 12. Action is taken to include the \$4000 as income for December for Medicaid Income purposes. On December 19, notice is issued to allow advance notice of the increase in Medicaid Income effective December 1 and closure for December 31 due to excess resources for January.

The amount of Medicaid Income due for the month will be the actual shown on the notice or the Medicaid reimbursement rate for the facility, whichever is less. The client or representative must be advised to contact the facility to obtain the lesser of the two amounts.

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Temporary Increase in Medicaid Income

When excess resources are not an issue, but receipt of additional income results in the monthly income total being over the income limit for LTC, the case will remain open if, for whatever reason, there is not time to allow advance notice of closure. However, if there are 10 calendar days left in the month, Medicaid Income must still be increased to the amount of that month's income or the Medicaid reimbursement rate for the facility, whichever is less. The client or representative must be advised to contact the facility to obtain the lesser of the two amounts.

For the following month, eligibility will continue. The additional income will be removed from the Medicaid Income calculation and Medicaid Income will return to the amount in effect prior to the temporary income increase.

Example: A client receives a lump sum VA payment of \$2500 in December which is reported to the regional office on December 21. The office became aware of the income too late to close the case; however, action is taken on December 21 to include the \$2500 as income for December for Medicaid Income purposes. On December 21, notice is issued to allow advance notice of the increase in Medicaid Income effective December 1. The lump sum did not cause resources to exceed the limit; therefore, eligibility continues. The income is removed from the Medicaid Income calculation and Medicaid income returns to the prior amount effective January.

101.15.02 CHANGE TO A REDUCED SERVICE COVERAGE GROUP

Changing from a full service coverage group to a reduced coverage group requires advance notice before the change can be effective the following month. It is not possible to change an active full service case to a reduced service coverage group such as QMB, SLMB, or QI in MEDS for the following month unless there are at least 12 days remaining in the current month.

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101.16 OTHER CHANGES

❖ Families, Children and CHIP Programs

101.16.01 TRANSITIONING THE PREGNANT CHIP CHILD TO 88 MEDICAID

For most children, program changes are effective only at review because of the continuous eligibility provision for children. However, when the agency becomes aware that a CHIP child is possibly pregnant, a special review must be completed to verify pregnancy/due date and to determine if the minor is eligible for Medicaid coverage as a pregnant woman. If so, the child will transition from CHIP to 88 Medicaid for the duration of the pregnancy and 2-month post partum period. However, if the office learns of the change too late, i.e., the minor is at the end of her pregnancy or has already delivered, no action is taken to change the program.

The program transition from CHIP to Medicaid is not an adverse action. If action is taken for the current month by the CHIP deadline, CHIP will terminate at the end of the current month and the pregnant minor will move to 88 Medicaid the following month. The head of household is issued a notice which contains the following information about the child's eligibility:

- Date the pregnant child will be removed from CHIP;
- Date the child will be eligible for Medicaid as a pregnant woman;
- The verified delivery date and the requirement to report an earlier or later date;
- Date the child will become ineligible for Medicaid as a pregnant woman;
- Date CHIP eligibility will resume;
- The child's review due date;
- Information about coverage for a 2-month post partum period;
- The deemed eligible provision for children born to Medicaid-eligible women.

If there are months remaining in CHIP at the end of the post partum period, the child will return to CHIP until review. If the pregnant minor's review comes due while she is on 88, the review will be completed. If the child is eligible for full Medicaid, action can be taken immediately to change the child from 88 to 91 or if applicable, 85. If the child continues to be CHIP-eligible at review, the new 12-month eligibility period is effective at the end of the post partum period. For programmatic and system instructions for implementing the change from CHIP to 88 Medicaid, refer to the FCC program section.