

MISSISSIPPI DIVISION OF MEDICAID

Eligibility Policy and Procedures Manual

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.