TABLE OF CONTENTS

SECTION C – APPLICATION AND REDETERMINATION PROCESS

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

A. OPPORTUNITY TO APPLY

The Division of Medicaid must afford an individual wishing to do so the opportunity to apply for Medicaid without delay.

B. PERSONS WHO CAN FILE

Medicaid requires that a written application form be filed by:

1. Applicant

The individual in whose behalf the application is filed.

2. Legal Guardian or Conservator

The application must be made in the name of the applicant but the guardian or conservator must give eligibility information and sign the Application Form. Proof of legal guardian or conservatorship will be required in the form of court papers.

3. Authorized Representative

This is a person who has been authorized in writing by the applicant to act in behalf of the applicant. An application must be filed in the name of the applicant and the Application Form will be completed from information provided by the authorized representative who will sign the Application. Proof of authorized representative status is required in writing. DOM-302 is used for this purpose.

4. Designated Representative

This is someone 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 must be someone who is knowledgeable of the applicant's financial affairs and will usually be a close relative or friend. The designated representative will be required to sign DOM-302, Designated Representative Statement to document his status. The application will be made in the name of the applicant with the designated representative providing the eligibility information and signing the Application Form.

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

C. APPLICATION DEFINED

An application is the action by which an individual indicates to the Regional Office on the agency Application Form, DOM-300, his desire for medical assistance. The DOM-300 must be completed by one of the persons described above.

1. Application Date

The application date is the date the DOM-300 was completed in the presence of a Regional Office staff member by one of the persons who can file or the date a signed application is received by mail. Applications received by mail which arrive after the end of the month, but which were postmarked on the last day of the month or a prior date will be considered to have an effective date of the last day of the month in which they are postmarked.

2. 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 process or a redetermination of eligibility.

3. Where the Application Shall be Filed

The application must be filed with the Regional Office responsible for the county in which the applicant is currently residing. However, due to the circumstances of a client unable to act for himself, a person authorized to act for the client who lives in another region's area may request assistance from the Regional Office nearest him in completing the Application Form, etc. In such instances, the staff in the Regional Office where the authorized person is located will give assistance in completing the application form, making copies of any necessary documents, etc., and assist the authorized representative in forwarding the application to the Regional Office where the applicant is located. The Regional Office where the applicant is located will be responsible for accepting, registering, and completing the application.

APPLICATION AND REDETERMINATION PROCESSING

APPLICATION PROCESS

In instances where the applicant is in one Regional Office area when he applies and moves to a second Regional Office area before the application is completed, the first Regional Office will complete the application and then transfer the record to the second Regional Office after final disposition of the application has been made.

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

D. METHODS OF MAKING APPLICATION

The right to apply for Medicaid is a basic right under State and Federal law. The Regional Office accepts applications for aged, blind and disabled applicants who do not receive SSI benefits and applications for illegal aliens who have received emergency services covered by Medicaid. The Regional Office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, except for holidays.

The methods of applying are:

1. Visit to a Regional Office (RO)

An applicant or representative must be given the opportunity to apply without delay when an individual visits a Regional Office in order to apply for Medicaid, he/she will be given the opportunity to complete the DOM-300.

2. Contact With RO Outside the RO

Regional Office eligibility staff are authorized to accept applications while on official duty outside the Regional Office. Such contacts may occur while the staff member is at a contact center, nursing home, hospital or other public facility.

3. Applications Received by Mail

The DOM-300 may be completed and mailed to the Regional Office. The date of application is the date the DOM-300 is received in the Regional Office or the date postmarked, whichever is earlier.

4. Applications Received by Fax

Regional Office eligibility staff are authorized to accept applications by fax. The application with the original signature should be mailed in and filed in the case record. The date of the application will be the date that it was faxed to the Regional Office.

APPLICATION AND REDETERMINATION PROCESSING

APPLICATION PROCESS

5. Inquiry or Referral

Anyone who inquires about eligibility requirements should be told of the opportunity to apply. If an application is desired, the Regional Office must mail out the DOM-300 if one is requested. The application will not be considered filed until received back in the Regional Office. An application can be completed by telephone with the worker using the DOM-300. The signature page can be mailed out. The date of the application will be the date the signed signature page is returned.

If another person or agency refers the name of an individual in need of medical assistance to the Regional Office, the Regional Office will mail an application to the individual if sufficient information regarding a mailing address is provided.

6. Requests for Application

By Out of State Applicant

Applications for Mississippi residents who are temporarily out of State may be accepted but the applicant must return to State before the application processing period ends. Exception: If the applicant is hospitalized in another State but plans to return to Mississippi upon discharge, then the application may be processed in the usual manner.

E. DETERMINING INITIAL ELIGIBILITY

To determine eligibility each eligibility factor must be established and the case record documented with verification of each factor. The technical and financial factors of eligibility are set out in Sections D-H. The steps in determining initial eligibility are as follows:

1. **Interview**

There is no requirement for an in-person interview. If a client specifically request an in-person interview, an interview will be granted. If anyone wants to come into the office to apply and requests assistance with completing the form, an in-person interview would be appropriate. Mail-in applications are accepted with telephone contact if the application is not complete. Telephone interviews are conducted on any application if information given is questionable or unclear.

2. Explanations Required At The Interview

The following items must be explained if an interview is conducted:

- the applicant may be assisted by the person of his/her choice.

- the eligibility factors pertinent to the coverage group under which the applicant is applying.

- the use and purpose of the DOM-300 including the fact that the applicant is agreeing to all of the rights and responsibilities specified on the application by signing the form.

- the Quality Control review process as stated on the DOM-300.

- that coverage is limited to only one source of eligibility, i.e., AFDC, SSI or MAO. If the individual is eligible under another source, that source must terminate prior to MAO eligibility beginning.

- the standard or promptness applicable to the case (outlined in the following discussion).

- the assignment of rights requirement as stated on the DOM-300.

- the use of SSN's in computer matching programs as stated on the DOM-300.

- that verification of eligibility factors is required and that the applicant must provide all information requested.

- the right to a local or state hearing (with a hearing pamphlet provided).

- the Medicaid services available to all eligibles (with a Services pamphlet provided).

3. Conclusion of Interview

The applicant or representative must have an understanding of:

- what the applicant must provide for eligibility to be determined,

- what the agency must do to determine eligibility, and

- what the end result will be, i.e., written approval or denial and the issuance of Medicaid cards and/or the right to appeal any decision.

The worker will also explain that, if approved, a redetermination of eligibility is conducted annually or more frequently if necessary.

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

F. STANDARDS OF PROMPTNESS

Federal regulations at 42 CFR 435.911 define timely determinations of eligibility. The time standards set cover the period from the date of application to the date the agency mails notice of the decision to the applicant. These standards may not exceed:

1. Aged or Blind Applications

45 days.

2. Disabled Applications

90 days. Exception: If a separate DDS decision is not required because the applicant draws RSDI disability benefits, the 45 day standard applies to the application.

3. Exceptions for Agency Delay

These standards do not apply when a decision cannot be reached because of:

a. Failure or delay on the part of the applicant.

b. Administrative or other emergency delay that could not be controlled by the agency such as:

- Staff vacancies or illness of eligibility staff members lasting two months or more.

- Wholesale desk reviews on active cases mandated by court order, or Federal regulations of wholesale increase in benefits such as Social Security, VA etc., which require extensive staff time.

- Computer problems arising from control of machines by an outside agency.

DOM-303 is used to notify the applicant of any agency delay in processing. The Notice of Delay will clearly state the reason for the agency delay.

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

G. REVIEW AND EVALUATION OF ELIGIBILITY INFORMATION

The worker must determine eligibility based on information secured during the initial interview and information contained on DOM-300. Appropriate DOM Forms must be present in the case record as the basis for the determination along with other legal or official documents secured which documents and supports the eligibility decision.

In addition to the completion of the appropriate DOM Forms, there are other supporting documents that the worker must obtain, if applicable, before eligibility can be determined. Documents such as legal deeds, wills, tax receipts, statements from knowledgeable sources, etc., are also required in cases involving resources. Refer to Sections D-H, for specifics.

After all applicable forms are completed and other required documents obtained, an eligibility decision is reached and the client is notified. No application will be held after the Regional Office has made the eligibility decision unless awaiting termination of Medicaid eligibility through another source. If, however, the needed information is not received after issuing DOM-307, 309, and, if applicable, DOM-303, the application must be denied.

1. Regional Office Supervisor Responsibility

After the worker makes the eligibility decision, the case is submitted to the Supervisor for review. The Supervisor is responsible for the accuracy, completeness, and consistency of information contained in the case record. The Supervisor attests to the validity of the information when signing off on the case in MEDS.

2. Concept of the Prude Man

This term is sometimes called the "reasonable man"and is taken from the practice of law. It refers to the element of judgement that is exercised by persons in making choices, determining goals and in evaluating statements of others.

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

Although all factors of eligibility must be verified, the concept of the prudent man must be used in evaluating and questioning information which the applicant has given which is not logical, consistent nor reasonable. Examples of use of the concept are:

- The worker must seek a reasonable explanation when a person has recently sold property or has owned other types of assets and suddenly becomes dispossessed of his holdings. It may be that the applicant has become senile, been cheated, or met with some other disaster, but the worker must gather as many facts as possible and then use reason and judgement in assessing the facts before making a decision as to the veracity of the explanation.

- The worker should seek further information or a logical and reasonable explanation of the circumstances when the applicant declares no income or resources but states that his payment for shelter, utilities, food, etc., are all current. The worker 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 and reasonable explanation for this, such as: (1) he has had income in the past which was recently terminated as in the case of loss of employment; (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 at a store, obtaining loans, etc. When the applicant or recipient can offer and substantiate no logical and reasonable explanation as to how he had paid his past living expenses with no income or resources, and offers vague explanations such as" "I just get by," etc., then eligibility cannot be determined and the application must be denied or assistance terminated for this reason.

APPLICATION AND REDETERMINATION PROCESSING
APPLICATION PROCESS

H. DENIAL OF ELIGIBILITY DUE TO FAILURE TO PROVIDE INFORMATION

Medicaid eligibility cannot be determined solely on the basis of declarations of information by applicants or clients or representatives. It is necessary to verify information through independent or collateral sources and obtain additional information necessary to be sure that only eligible individuals are enrolled in the Medicaid Program. The authority for obtaining this verification is found in 42 CFR 435.721 which specifies that Medicaid must use SSI eligibility requirements and Section 1631(e) of the Social Security Act.

Applicants and their representatives must provide information about each factor of eligibility. Medicaid will verify the information provided through documents, records and statements from third party sources, such as governmental or nongovernmental agencies, businesses and individuals. When documents are available from the applicant, they are asked to provide such proof.

If circumstances warrant it, information is obtained direct from third parties. The general rule for verification is to verify information which is material to an individual's eligibility. Refer to the section explaining each eligibility factor for specific verification and development requirements.

1. Competence of Applicant

When the worker observes that the applicant is mentally and physically competent to understand his role in establishing eligibility, or has a family member or close friend who can and will assist in this process, the worker will:

a. Be clear during the application interview about the steps which the applicant is to take.

b. Confirm these steps in writing via DOM-307, Request for Information.

2. Make one follow-up at the end of 10 days via DOM-309 when the applicant does not supply the necessary information or take the necessary action to determine eligibility.

When the worker determines that the applicant is mentally or physically incompetent or is unable to read and write when these activities are required, a designated representative must be found. The worker will determine whether there is some family member or close friend who can understand the steps normally required of the applicant and who will become his designated representative. The person who signs DOM-300 or DOM-300A must be competent and knowledgeable enough to attest to the accuracy of the information supplied on the form.

If the applicant fails to respond to the Second Request for Information, reject the pending application at the end of the standard of promptness because of the refusal of the applicant, or his failure after due notice to take any of the necessary steps to establish his eligibility or ineligibility. When this occurs, the application is rejected because the agency is unable to establish eligibility or ineligibility.

2. Reasonable Effort to Assist Applicant

It is required that the worker make a reasonable effort to assist the applicant in order to have the applicant's eligibility determined determined. This includes:

- help with completion of DOM-300,
- help with securing a representative, if needed,
- assisting the applicant in obtaining necessary information/evidence from third parties,
- provide information that will assist the applicant in making informed decisions about Medicaid eligibility. Medicaid program policies are public information and the applicant has a right to know the policies that will impact his/her eligibility.

APPLICATION AND REDETERMINATION PROCESSING
COVERAGE PERIODS FOR MEDICAID

A. BEGINNING DATES OF ELIGIBILITY

An applicant for Medicaid, including one who dies prior to fiing an application or dies prior to completion of the application, 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 the conditions set out below for retroactive Medicaid are met.

B. RETROACTIVE ELIGIBILITY FOR MEDICAID

In accordance with 42 CFR 435.914, an applicant for Medicaid may qualify for Medicaid coverage for a three-month period prior to the month of the application. Retroactive eligibility can cover all three months of the prior period, or any month(s) in this three-month period, provided the following conditions are met:

The provision of retroactive medical assistance for up to three (3) full months prior to the month of the application is mandatory for all applicants who:

- have received services covered by Title XIX (Medicaid) during any of the three-month period; and

- meet all eligibility criteria in the retro-active month(s) when the service was provided.

An individual who is not eligible at the time of the application may be eligible for retroactive medical coverage. An application for retroactive eligibility may be made on behalf of a deceased individual.

NOTE: SSI eligibles may be eligible for additional months of eligibility beyond the SSI retroactive period. This period of coverage is the month of application for SSI and any other missing months of SSI eligibility that exists until the month the SSI payment begins. The SSI eligible must apply for and be determined eligible for MAO coverage for this "interim" period of missing SSI eligibility.

C. BEGINNING DATE OF ELIGIBILITY FOR MEDICAID ELIGIBLES WHO MOVE TO MISSISSIPPI

When a Medicaid eligible moves to Mississippi from another state, it is possible for the individual to be considered a resident of Mississippi in the month of the move, provided the individual intends to reside in Mississippi. There are no durational limits on residency requirements; however, no individual is entitled to a duplication of Medicaid services from the state of former residence and Mississippi.

In the event an individual who is receiving Medicaid from another state moves to Mississippi and applies for Mississippi Medicaid, the following guidelines are to be followed:

1. Nursing Home Eligible

When an individual transfers from an out-of-state nursing home to a Mississippi nursing home, the issue regarding payment of nursing home claims must be resolved by contact with the Medicaid Agency in the former state of residence. The Regional Office handling the application must contact the Medicaid Agency by telephone or letter to determine if that state will pay the Mississippi nursing home claim for the month of the move and any subsequent months prior to termination of that state's Medicaid eligibility. If the state of former residence refuses payment, i.e., they do not pay out of state claims, then there will be no duplication of services and Mississippi Medicaid eligibility can potentially begin with the month of the move.

If the former state of residence will pay for the partial month or any subsequent months, eligibility for Mississippi Medicaid cannot begin until the state of former residence specifies their payment(s) will stop.

The case record must be documented with the out-of-state contact and the response concerning payment.

2. At-Home Eligible

If a Medicaid client living at home in another state enters a a Mississippi nursing home, the same procedures as outlined in 1 above applies. An individual living at home, who applies for Medicaid, must have the beginning date of eligibility coordinated with the former state of residence. The same procedure outlined in 1 above is necessary regarding contact with the state of former residence to determine when Medicaid will terminate and whether out-of-state payment of claims is customary. If no out of State payment is anticipated, eligibility can begin with the month of the move to Mississippi if eligible on all other factors.

D. TERMINATION DATES FOR MEDICAID

Medicaid coverage for a recipient will end on one of the following days of the month:

- The last day of the last month in which the client was eligible.

- The death date of the recipient.

APPLICATION AND REDETERMINATION PROCESSING
REDETERMINATIONS

A. PURPOSE

Redeterminations on Medical Assistance Only cases must be performed on a regular basis to determine if a client remains eligible for Medicaid benefits. The redetermination process is essentially the same as the application process in that the client's entire situation must again be reviewed for regular redeterminations. Special reviews require that only the reported change be considered rather than all eligibility factors.

1. **Factors That Do Not Require Reverification**

Certain technical factors of eligibility which are and/or verified during the application process need not be reverified during a redetermination unless a change has occurred or a discrepancy exists

- Age.
- Disability. However, if DDS has requested on the most recent DOM-325 that a re-examination is necessary, the case will be resubmitted to DDS on the date requested by DDS.
- Citizenship and Residency.
- Physicians Certification approving need for long-term-care clients.
- Social Security Number of client.

2. Factors That Require Reverification

Other technical factors such as living arrangements, utilization of other benefits, or any other factor that has changed since the last application/redetermination process must be reverified.

Note: It is mandatory to verify the current living arrangement of each recipient at each redetermination, i.e., verify that the recipient continues to reside in the same type of living arrangement or nursing facility as previously reported.

APPLICATION AND REDETERMINATION PROCESSING
REDETERMINATIONS

Financial factors of eligibility are the most likely to change. For this reason, income and resources must be carefully reviewed at each regular redetermination.

Obtain a tax receipt each year for nursing home cases.

Obtain one bank statement or other means of documenting bank balances. A verified balance from the bank is acceptable. Give the client the 330 to take to the bank or ask the client to get a statement or receipt from the bank. Only one verified balance, with date, is needed. If a bank statement is received that shows odd deposits, use the prudent man concept to determine if this is on going income.

APPLICATION AND REDETERMINATION PROCESSING
REDETERMINATIONS

B. TYPES AND FREQUENCY OF REDETER-MINATIONS

Redeterminations are classified as either regular or special reviews of a client's case.

1. Regular Reviews

A regular review must be performed on each MAO client's case at intervals not to exceed 12 months. A regular review is a complete redetermination whereby DOM-300A is completed by the client or representative and each eligibility factor is examined.

Note: SSI Nursing Home cases are redetermined each 12 months to recalculate Medicaid Income only and issue an updated DOM-317.

No designated time limit exists for completion of regular redetermination since eligibility does not expire at the end of 12 months. Cases which are not current simply become overdue. The regular redetermination process should begin two months prior to the end of the review due date, meaning DOM-300A should be issued at this time, thereby allowing time for completion before the case becomes overdue.

1. **Telephone Redeter-minations**

A telephone redetermination can be completed using the DOM-300A Form. The client's signature is not needed. Document the Household Composition for nursing home cases. Also, document what was verbally requested during the telephone redetermination. Set a ten (10) day manual tickler for information needed. After 10 days, send a Second Request (309) if the information has not been received.

3. Exception Telephone Interviews

When it is impossible to contact a client by telephone, the Redetermination Form, DOM-300A, should be issued along with DOM-307, Request for Information. DOM-307 must specify the types of verification known to be needed upon return of the completed DOM-300A. A time limit of 10 days is allowed for completion of Form-300A and the submission of requested information.

DOM-309, Second Request for Information, must be issued at the end of 10 days if the information requested via DOM-307 is not timely submitted. Note, however, the instructions to DOM-307 which specify that if new or additional information is required upon return of the completed DOM-300A, and this information was not included on the first DOM-307, it is necessary to issue another DOM-307 requesting information for the first time.

DOM-306, Notice of Adverse Action, must be issued to close the case if required information is not received after DOM-307 and DOM-309 have been issued and the appropriate 10-day notices have expired.

Do not close a case for failure to return the needed redetermination information without a documented telephone contact that effort(s) were made to contact the client prior to closing the case. This means an additional telephone contact is required, other than the redetermination interview.

4. Special Reviews

Special redeterminations can occur, as outlined below, whereby a complete review is not required nor due; however, a portion of the case must be reworked.

Special determinations of eligibility are necessary when:

- the client reports a change in his circumstances which could affect eligibility or level of benefits,
- information from any other source is received which could affect eligibility or level of benefits,
- potential changes in eligibility are indicated by information already available,
- it is necessary to transfer the case record to another Regional Office.

If additional information is needed to act on reported charges, then the client must be notified in writing via the use of DOM-307 and DOM-309 Forms allowing the client sufficient time to provide the information.

APPLICATION AND REDETERMINATION PROCESS
REDETERMINATIONS

C. SSI REDETERMINATIONS

Individuals terminated from SSI due to income and/or resources are issued an SSI Termination Notice (Section B) and an SSI Redetermination Form, DOM-300B, by the fiscal agent upon receipt of the SDX notification of termination. This form is to be completed and returned to the appropriate Regional Office if the client desires continued Medicaid and is eligible under one of the coverage groups described in the SSI Termination Notice. SSI clients who are terminated from SSI and receive this form do not require an in-person interview but all necessary factors of eligibility must be verified; i.e., disability, residency, utilization of other benefits, etc. Needed information must be requested in writing to the client including DOM-TPL Form 406, Third Party Liability Information, since this form is not part of the SSI Redetermination Form issued by the fiscal agent with the SSI Termination Notice.

APPLICATION AND REDETERMINATION PROCESSING
NOTIFICATION PROCESS

A. NOTICE TO CLIENT

The client must be notified in writing, via the appropriate DOM Form, of any action taken on the client's application or active case which affects eligibility or level of benefits. The appropriate notice to use depends on the type of action taken on the case as outlined below:

1. DOM-305, Notice of Action

This notice to the client is used when the action taken on an application or active case involves any of the following:

- Approval of application. This form is used to approve retroactive benefits, ongoing eligibility, or a combination of the two. The effective date of approval and the amount of Medicaid Income, if any, will be shown on the form. DOM-305 is used when approving only a portion of the benefits applied for, e.g., when the applicant applied for 3 months retroactive benefits but can only be approved for 1 month. If a portion of the benefits applied for are to be denied or if eligibility will expire at a predetermined time, an explanation must be provided in the remarks section of the form.

- Approval of redetermination. For nursing home clients this form is used to approve the redetermination or special review of a case, provided benefits remain the same or increase, meaning the client's Medicaid Income is reduced. If Medicaid Income increases, this is considered a reduction in benefits and, thus, results in an adverse action. Refer to the following subsection for policy outlining the effective date of action for changes.

- Transfer of case to another Regional Office. This form is used to notify the client when the case record is transferred to another Regional Office. The address of the Regional Office that will handle the case will be posted on the form.

APPLICATION AND REDETERMINATION PROCESSING
NOTIFICATION PROCESS

The Notice of Action includes a statement concerning the client's right to a fair hearing. However, the fair hearing statement does not include the 10-day advance notice for continuation of benefits, as this provision is not applicable to approval of applications or an increase in benefits. The applicant or client has 30 days from the date of mailing posted on the form to request a hearing if dissatisfied with the action taken on the case.

2. **DOM-306, Notice of Adverse Action** - This notice is used when the action taken on an application or active case involves any of the following adverse actions:

- Denial of application. This form is used when all benefits applied for must be denied. The reason for the denial will be clearly stated in the space provided on the form. Although a denial is an adverse action, there is no need to hold the denial for 10 days, since the continuation of benefits provision does not apply.

- Closure of active case. This form is used to close a client's case. The effective date and reason for the closure will be clearly stated in the space provided and the continuation of benefits provision applies as outlined below. Refer to the following subsection for policy outlining the effective date of closure.

- Increase in Medicaid Income. This form is used to report an increase in Medicaid Income for nursing home/hospital clients. The effective date and reason for the increase will be clearly stated in the space provided and the continuation of benefits provision applies outlined below. Refer to the following subsection for policy outlining the effective date of increases in Medicaid Income.

APPLICATION AND REDETERMINATION PROCESSING
NOTIFICATION PROCESS

- Termination of Nursing Facility vendor payment. This form must be used to terminate a client's vendor payment in instances where a transfer penalty is to be applied or a nursing facility level of care is denied or terminated. Advance notice to terminate the vendor payment is required for MAO and SSI-only clients

- Conversion to a reduced services coverage group. This form is used to notify the client that eligibility for full Medicaid services is being terminated and eligibility will continue for reduced services only, such as QMB or SLMB.

APPLICATION AND REDETERMINATION PROCESSING
NOTIFICATION PROCESS

B. ADVANCE NOTICE PERIOD

Federal regulations mandate that the agency mail a notice of of adverse action 10 days before the date of action to reduce or terminate Medicaid benefits, except for situations classified as "Exceptions to Advance Notice." The required advance notice period is 10 calendar days beginning with the day after the date of mailing which is posted on the DOM-306. However, for MEDS purposes the actual advance notice period is 12 calendar days from the end of a month to allow for notice processing and mailing. It is mandatory that the Notice is mailed out on the date posted as the date of mailing so that the client is allowed the maximum advance notice time in order to timely request a hearing whereby continuation of benefits applies.

During the 12-day advance notice period, the agency cannot authorize any action to reduce or terminate benefits. If action is erroneously taken to reduce or terminate benefits during the advance notice period and the client requests a hearing during the advance notice period, benefits must be reinstated as discussed in the following subsection.

1. Continuation of Benefits

This provision applies to any action taken to reduce or terminate Medicaid benefits. Form DOM-306, Notice of Adverse Action, contains space for the worker to enter the date which represents the last day of the advance notice period. This is the 12th calendar day from the day after the date of mailing which is posted on the notice. If a client requests a fair hearing during the 12-day advance notice period, the agency may not reduce or terminate benefits until the final hearing decision is rendered. For a detailed discussion on how to determine if a hearing is requested timely in order for continuation of benefits to apply, refer to the Hearings Section.

APPLICATION AND REDETERMINATION PROCESSING
NOTIFICATION PROCESS

2. Exceptions to Advance Notice

The following situations represent exceptions to advance notice whereby the action does not have to be held; however, the DOM-306 must be issued:

- The agency has factual information confirming the death of a client.

- The client submits a voluntary request for closure of his/her case. This request must be in writing, signed by the client or his/her designated representative.

- The client is admitted to a public institution, e.g., prison or a State hospital in a non-Title XIX facility.

- The recipient's whereabouts are unknown and the Post Office returns agency mail indicating no forwarding address. If the client's whereabouts become known during the time the client is eligible for services, the case must be reinstated.

- The agency establishes the fact that the client has been accepted for Medicaid services by another State.

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

A. TIMELY ACTION ON CHANGES

The worker must follow up on any information resulting in a change in a client's circumstances which is reported or becomes known to the agency. Changes affecting eligibility should be processed as soon as the change becomes known to the agency. Action must be taken to initiate the change no later than 10 working days from the date the change becomes known. The case record must reflect that action was initiated to process a change within this 10-day time period.

Changes include:

- closures
- increases or decreases in Medicaid Income
- procedural changes such as transfer between programs, etc.

Changes require that the client be notified of the change via the appropriate notice to the client and that the medical facility be notified, if appropriate, via DOM-317. The following policy discussion specifies the effective dates to use in notifying the client and medical facility.

B. CLOSURES

Advance notice is always required before a case can be closed. This means that there must be 12 days left in the current month in order to close a case for the following month. This allows for the 10-day advance notice period plus 2 days mailing time. During the advance notice period the client has the right to request a fair hearing and has the right to continuation of benefits pending the hearing decision if timely requested.

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

1. Death Closures

If a client's death has been verified, the case will be closed as of the actual death date. Advance notice is not required.

The date of death must be established and date and source of verification recorded in the case folder. The following sources of verification are acceptable:

- viewing death certificate
- contact with the funeral home or attending physician
- signed statements from two (2) persons who can attest to the date of death
- dated newspaper clippings
- contact with the hospital or nursing home where patient died

2. Temporary Closure of Two Months Or Less

In situations where it is known that a client will be ineligible for two months or less, the closure will be processed in the normal manner; however, at the end of the temporary ineligibility 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 the ineligibility will exist
- the date the recipient will again be eligible
- the reason for the temporary ineligibility

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

C. CHANGES IN MEDICAID INCOME (MI)

Changes in a client's income, marital status or non-covered medical expenses will impact the amount of income the client must pay toward the cost of his/her care, known as Medicaid Income. These changes will result in either a decrease or increase in Medicaid Income. The effective dates of these changes are determined as follows:

1. Decrease in MI

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 at any time during the month of June will be effective as of June 1. Notice to the client (DOM-305) and notice to the medical facility (DOM-317) will specify June 1.

2. Increase in MI

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 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 that the worker has 10 days before Medicaid makes its payment to a facility to increase Medicaid Income for the current month. Since payment schedules to nursing homes 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.

For example, if an increase in the client's income is discovered on October 10, an increase in Medicaid Income can be effective October 1 provided advance notice is issued regarding the increase by October 21.

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

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

When Medicaid Income is temporarily decreased due to the allowance of a deduction, i.e., a health insurance premium or other non-covered medical expense, and Medicaid Income is subsequently returned to an 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 a deduction, the notice should advise that Medicaid Income will return to the previous amount and specify the previous 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.

3. Increase in MI 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 counted in the Medicaid Income computation in the month of receipt provided there are 10 calendar days remaining 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 for the following month. Both actions are accomplished by use of one DOM-306, Notice of Adverse Action, explaining the increase and the closure.

Example: A client receives a lump sum VA payment of $4000 on 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. DOM-306 is issued December 19 which allows advance notice prior to January 1. DOM-306 shows a Medicaid Income increase for December and a closure for December 31 due to excess resources for January.

APPLICATION AND REDETERMINATION PROCESSING AUTHORIZING CHANGES

The amount of the excess income will be shown on the DOM-306 and DOM-317 Forms; however, the client/representative should be advised that the amount due for the month will be the actual income shown or the Medicaid reimbursement rate for the particular facility, whichever is less. The client/representative must contact the facility to obtain the lesser of the two amounts.

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

D. CHANGES TO REDUCED SERVICES COVERAGE GROUPS

Changes from a full services coverage group to a reduced group, such as QMB or SLMB, require advance notice before the change can be effected in the following month. It is not possible to change an active case to a reduced services coverage group unless there are 12 days remaining in the current month.

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

E. PROCEDURAL CHANGES

The types of changes discussed below are considered procedural since Medicaid benefits are continued at the same level. Procedural changes are reported via MEDS and include the following:

- Change of address (Notice to the client is not required.)

- Change in name due to:

- error made in the original listing of the name

- change in marital status

- change or appointment of guardian/conservator

Changes in name should also be posted on all other permanent records which carry the client's name, such as master card(s), case record, etc. (Notice to the client is not required.)

- Transfer between programs. MEDS should be corrected to change category when a disabled or blind client turns 65 years of age and becomes an aged client. (Notice to the client is not required.)

- Transfer between Regional Office. (Notice to the client is required).

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

F. CORRECTIVE ACTION

At the time the Regional Office becomes aware of an error present in the case record which affects eligibility or level of benefits, action must be initiated to correct the error. Immediate corrective action is handled as a change, outlined in the preceding policy discussion, and prevents further error. However, in some instances, it is also necessary to correct the error retroactively into prior months.

When corrective action into prior months adversely affects the client, meaning that the client was ineligible or eligible for fewer benefits, DOM-354 is prepared. Refer to Section K, "Improper Medicaid Benefits."

When corrective action into prior months favorably affects the client, meaning that the client was eligible or eligible for more benefits, the corrective action is handled as a reinstatement as outlined below.

APPLICATION AND REDETERMINATION PROCESSING
AUTHORIZING CHANGES

G. REINSTATEMENTS

Certain situations require a reinstatement of services which means that either eligibility is restored or Medicaid Income is corrected for a prior period. Either type of reinstatement is accomplished without requiring that a new application be filed on behalf of the recipient. A reinstatement of services is in order in the following situations:

1. Hearing Decision

A hearing decision is rendered as a result of a State or local hearing which grants eligibility or increased benefits. Based on the findings of a State or local hearing, the Regional Office may be required to reinstate eligibility or correct Medicaid Income, whichever is appropriate, retroactive to the date decided by the hearing official.

Note: If benefits were continued pending the hearing decision on an active case, reinstatement may not be required unless the decision at the hearing is to increase the level of benefits in effect prior to the hearing.

2. Advance Notice Period

Proper advance notice policy is not followed as outlined in the "Notification Process" subsection for adverse actions. This includes situations where:

a. Appropriate advance notice is issued; however, the client timely request a hearing during the advance notice period.

b. Advance notice to reduce or terminate benefits is not issued as required; therefore, benefits must be reinstated at the time the error is discovered, regardless of whether the client is currently eligible. Benefits must be reinstated and the appropriate advance notice issued.

3. Client's Whereabouts Become Known

A client's whereabouts are unknown as indicated by the return of unforwardable agency mail directed to him/her. Any discontinued Medicaid must be reinstated if his whereabouts become known during the time he/she is eligible for Medicaid. To do this the worker must determine

eligibility for each month that the client's whereabouts were unknown and reinstate for any period of time he/she would have been eligible.

4. Temporary Case Closure

A case is closed temporarily for 2 months or less.

Note: Although no new application is required for temporary closures of 2 months or less, a break in the client's eligibility correctly exists. Therefore, it is necessary to adjust the client's beginning Medicaid date via MEDS to reflect the most recent beginning Medicaid date.

5. Reapplication

A second application is requested on an application that has been in rejected status for less than 2 months. The rejected application can be updated and signed by the applicant or representative thereby establishing a new application date that supersedes the initial application date. However, all factors of eligibility that are not subject to change need not be reverified, i.e., disability, physician certification. Income and resource factors may require further verification, depending on the types involved.

The beginning date of eligibility is controlled by the second or updated date of application.

6. Agency Error

The agency discovers that eligibility was denied or terminated in error or that benefits were reduced in error due to agency failure to act on information present in the case record or information that was presented within the advance notice period that established eligibility.

The discovery of erroneous action may come about through:

- a review of the case or application,
- a complaint made by or for the applicant or client,
- recognition of the error by the worker, or

- other sources having knowledge of the error.

When the agency fails to act on information provided during the application/redetermination process or during the advance notice period, action must be initiated to reinstate benefits retroactive to the month in which the erroneous action took place. No corrective action to reinstate benefits is required when the information establishing eligibility was not provided to the agency either prior to or during the advance notice period; instead a new application must be filed.