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.

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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

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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.

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.

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.

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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.

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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).

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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.

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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.