MISSISSIPPI DIVISION OF MEDICAID

Eligibility Policy and Procedures Manual

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101.01 INTRODUCTION

This chapter provides information on coverage of categorically needy individuals in Mississippi and guidelines for processing applications, annual reviews of eligibility, special reviews of eligibility due to reported changes and reinstatements of eligibility for all Medicaid coverage groups and the Children's Health Insurance Program (CHIP).

- Coverage of the categorically needy is either mandatory or optional. Mandatory groups are required by the passage of federal laws and optional groups are authorized by the passage of state laws.
- The application process consists of all activities completed during the timely processing period from the time a signed application form is received by the agency until a notice of approval or denial is issued to the applicant.
- An annual review or renewal of eligibility is a full review of all variable eligibility factors, conducted at specific intervals, not to exceed 12 months for each recipient, to determine whether or not eligibility continues. Basic information that is not subject to change is not re-verified.
- A special review deals with reported changes that occur during a review period. The impact of each reported change must be evaluated to determine when, how and if the change impacts eligibility.
- A reinstatement reopens eligibility without requiring a new application or renewal form. Eligibility may or may not be reopened back to the date of closure, depending on the circumstances.

Other changes are also addressed in this chapter that are program specific, such as increases in Medicaid Income and transitioning pregnant women from their original source of eligibility to pregnancy related coverage, when necessary.

101.02 COVERAGE OF THE CATEGORICALLY NEEDY IN MISSISSIPPI

Medicaid programs in each state must provide coverage to specified categories of needy individuals that include:

- Children,
- Pregnant women,
- Parents or caretaker relatives of dependent children,
- Aged individuals and
- Disabled or blind individuals.

Within these broad categories of coverage, the specific groups covered are either:

- Mandatory – meaning federal law required coverage of the category, or
- Optional – meaning federal law allows coverage of the category and state law authorizes the coverage.

Coverage for children, pregnant women and parents and caretaker relatives are referred to as MAGI-related coverage due to the application of Modified Adjusted Gross Income (MAGI) standards to these groups. MAGI standards are financial methodologies used to determine eligibility. Income standards for MAGI-related coverage are referred to as MAGI-equivalent standards. Effective January 1, 2014, federal law referred to as the Affordable Care Act or ACA required that net income thresholds in effect prior to the ACA be converted to equivalent MAGI levels to account for income disregards eliminated by the ACA.

Coverage of the aged, blind and disabled are referred to as ABD coverage. ABD policy is based on the most closely related cash assistance program, which is the Supplemental Security Income (SSI) program. The ABD program area uses SSI policy rules except in categories that have been allowed to use more liberal methodologies through State Plan approval or in instances where Medicaid regulations implement Medicaid policy that takes precedence over SSI policy.

Refer to the Categories of Eligibility (COE) Chart in the Appendix page by the same name for COE designations, sources of eligibility and other identifying information that is pertinent to each group.

Certification Responsibilities

Medicaid is certified or authorized by the following entities:

1. The Social Security Administration or SSA,
2. The Mississippi Department of Child Protection Services or DCPS,
3. The Mississippi Division of Medicaid or DOM,
4. Qualified Hospitals that certify Hospital Presumptive Eligibility or HPE
5. Qualified Providers that certify Presumptive Eligibility for Pregnant Women or PEP

101.02.01 MANDATORY CATEGORICALLY NEEDY – MAGI RELATED

The following are MAGI-related coverage groups that must be covered, as required by federal law:

Mandatory Coverage of Parents and Other Caretaker Relatives

Coverage is mandatory for parents and other caretaker relatives who have a dependent child or children under the age of eighteen (18) living in the home whose household income is below the applicable limit established by the state for coverage. The limit established by the state is a MAGI-equivalent standard based on household size. The Division of Medicaid certifies eligibility for this group.

- Extended Medicaid coverage for twelve (12) months is mandatory for a family whose eligibility is based on family coverage if the family loses Medicaid coverage solely due to increased income from employment or increased hours of employment provided the family received Medicaid in any three (3) or more months during the six (6) month period prior to becoming ineligible, as determined by the Division of Medicaid.

Mandatory Coverage of Pregnant Women

Coverage is mandatory for pregnant woman whose household income is at or below the income standard established by the state, not to exceed 185% of the federal poverty level converted to a MAGI-equivalent standard. The Division of Medicaid certifies eligibility for this group.

- DOM must provide Medicaid for an extended period following termination of pregnancy to women who applied for and were eligible and received Medicaid services on the day that their pregnancy ends. This period extends from the last day of pregnancy through the end of the month in which a 12-month period ends.
- Eligibility must be provided regardless of changes in the woman's financial circumstances that may occur within this extended period.
- A review is required at the end of the 12-month period.

Mandatory Coverage of Newborns

Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible for one (1) year from the date of birth. This provision applies in instances where the labor and delivery services were furnished prior to the date of application and covered by Medicaid based on retroactive eligibility. The Division of Medicaid is responsible for certifying eligibility for deemed eligible newborns.

Coverage is mandatory for infants born to qualified or non-qualified alien mothers who qualify for Medicaid on all factors other than alien status who receive Medicaid based on emergency medical services, provided an application for emergency services is timely filed with the Division of Medicaid.

Mandatory Coverage of Infants and Children under Age 19

Coverage is mandatory for the following age-specific groups of children certified by the Division of Medicaid:

- Infants to age 1 in households whose income is at or below 185% of the federal poverty level converted to a MAGI-equivalent standard.
- Children age 1 to age 6 whose income is at or below 133% of the federal poverty level converted to a MAGI-equivalent standard.
- Children age 6 to age 19 are eligible for Medicaid if household income is at or below 133% of the federal poverty level. This limit is not converted to a MAGI-equivalent because federal law specifies 133% as the maximum limit.

Mandatory Coverage of Adoption Assistance and Foster Care Children

Coverage is mandatory for children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Social Security Act, as determined by the Department of Child Protection Services who certifies eligibility for this group of children.

Mandatory Coverage of Former Foster Care Children

Coverage is mandatory for former foster care children who are under age twenty-six (26) if the child was in foster care and Medicaid upon reaching the age of 18 or prior to age 21 when released from foster care. Continued Medicaid coverage is certified by the Division of Medicaid in coordination with the Department of Child Protection Services.

101.02.02 MANDATORY CATEGORICALLY NEEDY - ABD

The following are ABD coverage groups that must be covered, as required by federal law:

Mandatory Coverage of SSI Recipients

Coverage is mandatory for individuals receiving Supplemental Security Income (SSI) in Mississippi. This includes individuals receiving SSI pending a final determination of blindness or disability, those receiving SSI under an agreement to dispose of resources that exceed the SSI resource limit, and those receiving benefits under section 1619(a) or considered to be receiving SSI under 1619(b) of the Social Security Act. Coverage also includes those who would be eligible for SSI except for an eligibility requirement used in the SSI program that is specifically prohibited under title XIX. Eligibility for SSI is determined by the Social Security Administration. No separate application for Medicaid is required unless the individual needs to apply for retroactive Medicaid for up to three (3) months prior to the month of the SSI application, in which case the individual must apply with the Division of Medicaid for the retroactive period of eligibility.

Mandatory Coverage of Certain Former SSI Recipients

Certain former SSI recipients qualify for Medicaid to continue once their SSI terminates if the use of specific income disregards allows Medicaid eligibility.

Medicaid eligibility is based on SSI income and resource limits. The Division of Medicaid certifies eligibility for all the former SSI groups, as follows:

- Cost of Living Individuals – these are former SSI recipients who become ineligible for SSI cash assistance because of a cost-of-living increase in title II benefits received after April 1977. These individuals must be granted Medicaid coverage if the sole reason for the loss of SSI was an increase in RSDI benefits received by the individual and/or his or her financially responsible spouse.
- Disabled Adult Children – these are former SSI recipients age 18 or over whose disability onset date was prior to turning age 22. SSI must have been paid at any time after July 1987 and closed when title II benefits from a parent's record began or increased, whichever caused the SSI to terminate.
- Coverage is mandatory for certain disabled widows and widowers who would be eligible for SSI except for receipt of Social Security widow(er) benefits that terminated SSI. The individual must be age 50 through 64 and not eligible for Medicare to be evaluated for coverage under this provision.

Mandatory Coverage of Certain Medicare Cost-Sharing Groups

The Division of Medicaid certifies eligibility for all the Medicare cost-sharing groups:

- Qualified Medicare Beneficiaries (QMB) must be entitled to Medicare Part A and have income that does not exceed 100% of the federal poverty level. Medical assistance is limited to payment of Medicare cost-sharing expenses that includes premiums, co-insurance and deductible charges. Note: The only exception to the requirement of entitlement to Part A is made for individuals entitled to Medicare Part B-ID. Medicare Part B-ID, implemented January 2023 from the Consolidated Appropriations Act 2021, is solely for coverage of immunosuppressive drugs. Part B-ID may be awarded to individuals who lose Medicare entitlement based on end stage renal disease (ESRD) 36 months following a successful kidney transplant. Individuals are ineligible for Part B-ID if they have full Medicaid coverage that includes coverage for immunosuppressive drugs or other health insurance.

- Specified Low-Income Medicare Beneficiaries (SLMB) must be entitled to Medicare Part A and have income greater than 100% of the federal poverty level but less than 120% of the federal poverty level. Medical assistance for this group is limited to payment of Medicare Part B or Medicare Part B-ID premiums.
- Qualifying Individuals (QI) must be entitled to Medicare Part A and have income that is at least 120% of the federal poverty level but less than 135% of the federal poverty level. Medical assistance for this group is limited to payment of Medicare Part B or Medicare Part B-ID premiums under a federal allotment of funds. Eligibility for coverage as a QI is dependent on the availability of federal funds.
- Payment of the Medicare Part D pharmacy plan premium is applicable to the Medicare cost-sharing groups of QMB, SLMB and QI provided the beneficiary enrolls in a benchmark or $0 premium pharmacy plan. Benchmark plans are subject to change each calendar year based on plans that choose to participate within Mississippi.
- Qualified Disabled and Working Individuals must be entitled to Medicare Part A and have income that does not exceed 200% of the federal poverty level whose return-to-work results in the loss of coverage for Medicare. Medical assistance is limited to payment of the Part A premium.

101.02.03 MANDATORY CATEGORICALLY NEEDY – SPECIAL GROUPS

Mandatory Coverage of Certain Aliens for Emergency Services

Emergency services, including labor and delivery services, must be provided to aliens who meet all eligibility requirements for Medicaid coverage in any MAGI-related or ABD coverage group except for their alien status who need treatment of an emergency medical condition. Transplant services are prohibited. Coverage is limited to treatment of the emergency condition only. The Division of Medicaid certifies Medicaid coverage for Emergency Services for Aliens.

Mandatory Presumptive Eligibility Determined by Qualified Hospitals

Qualified hospitals must be allowed to determine presumptive eligibility for individuals eligible for Medicaid in certain Medicaid coverage groups, referred to as Hospital Presumptive Eligibility or HPE. HPE allows qualified hospitals to

immediately enroll patients in Medicaid who are determined eligible for Medicaid by authorized hospital staff. HPE provides temporary Medicaid eligibility but also allows access to continuing Medicaid coverage provided the HPE decision includes filing a full Medicaid application.

Medicaid coverage groups eligible for HPE decisions include children up to age 19, pregnant women, low-income parents or caretaker relative(s), former foster children and certain women with breast or cervical cancer. The Division of Medicaid is responsible for HPE Medicaid in conjunction with qualified hospitals that certify HPE eligibility.

Mandatory Coverage of Refugees Under the Refugee Resettlement Grant

Medicaid is provided to certain refugees under a Refugee Resettlement Grant administered by the Department of Child Protection Services (DCPS). Refugees that meet the eligibility requirements for assistance under the grant are eligible for time limited Medicaid. DCPS certifies the eligibility for all qualified refugees that receive assistance and reimburses DOM with funds from the grant for all medical assistance provided by DOM to eligible refugees.

101.02.04 OPTIONAL CATEGORICALLY NEEDY – MAGI-RELATED

Optional Coverage of Foster and Adoption Assistance Children

The Department of Child Protection Services (DCPS) certifies eligibility for the following optional groups of children who are in the custody of DCPS:

- Children under the age of 21 for whom the Department of Child Protection Services (DCPS) assumes full or partial financial responsibility who are in foster homes or private institutions are certified for Medicaid coverage by DCPS if the child's income is within state established standards, converted to a MAGI-equivalent standard.
- Children under age 21 in adoptions subsidized in full or part by DCPS and children in adoption assistance who cannot be placed for adoption without medical assistance due to special needs of the child are eligible for Medicaid regardless of the child's income, as determined by DCPS.

Optional Coverage of the Children's Health Insurance Program (CHIP)

The Division of Medicaid certifies eligibility for the Children's Health Insurance Program (CHIP). Uninsured children under age 19 whose household income is at or below 200% of the federal poverty level converted to a MAGI-equivalent standard are covered by CHIP, which is a separate health plan. Covered children include:

- Infants to age one (1) whose household income is between the MAGI equivalent standards of 185% - 200% of the federal poverty level;
- Children age one (1) to age six (6) whose household income is between the MAGI-equivalent income standards of 133% - 200% of the federal poverty level; and,
- Children age six (6) to age nineteen (19) whose household income is above 133% of the federal poverty level but below the MAGI-equivalent income standard of 200%.

Optional Presumptive Eligibility for Pregnant Women Determined by Qualified Providers

- Qualified providers are allowed to determine presumptive eligibility for individuals eligible for Medicaid in the pregnancy coverage group (COE 88), referred to as Presumptive Eligibility or Pregnant Women or PEP. PEP allows qualified, registered providers to immediately enroll pregnant patients in Medicaid who are determined eligible for Medicaid by authorized provider staff. PEP provides temporary Medicaid eligibility but also allows access to continuing Medicaid coverage provided the PEP decision includes filing a full Medicaid application.
- The Medicaid coverage group eligible for PEP decision is limited to pregnant women. The Division of Medicaid is responsible for PEP Medicaid in conjunction with qualified providers that certify PEP eligibility.

Optional Waiver Coverage – Family Planning

Section 1115 waiver coverage provides family planning and family planning related services to certain individuals who have family income at or below 185% of the federal poverty level converted to a MAGI-equivalent standard of federal poverty level. Waiver eligibility requirements include the following:

- Women and men, ages 13 – 44, may qualify for waiver participation.
- Waiver participants may not be otherwise eligible for Medicare, Medicaid, CHIP or other health insurance that includes coverage of family planning services.
- Individuals who have had surgery to prevent reproduction cannot qualify for waiver participation,
- MAGI non-filer household rules are applied to family income, excluding any non-taxable income sources. Applicants under the age of 19 are budgeted as a household of one with parental and other income disregarded.

The Division of Medicaid determines eligibility for participation in the Family Planning Waiver.

101.02.05 OPTIONAL CATEGORICALLY NEEDY – ABD

Optional Coverage of the Aged, Blind and Disabled Living At-Home

The Division of Medicaid certifies eligibility in full or in part for the following groups of optional ABD groups:

- Disabled individuals who work more than an established number of hours each month whose net family earned income is at or below 250% of the federal poverty level and whose unearned income is at or below 135% of the federal poverty level. Resource limits and other non-financial factors of eligibility are required. Premiums are payable for households with countable earnings that exceed 150% of the poverty level.
- Women who have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix. Coverage is limited to women who are uninsured and are otherwise not eligible for Medicaid under any other mandatory coverage group and

have not attained age 65. The MS State Department of Health is responsible for the screening, diagnosis and financial eligibility decisions; the Division of Medicaid is responsible for the non-financial eligibility decisions and for certifying Medicaid eligibility during the woman's active treatment.

Optional Coverage of the Aged, Blind and Disabled Considered to be in an Institution

- Individuals who would be eligible for cash assistance if not institutionalized. The individual must be in a title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.
- Individuals in institutions who are eligible under a special income test, including the use of an Income Trust, if applicable. The individual must be in a title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.
- Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid if in a medical institution and for whom the Division of Medicaid has made a determination as required under section 1902(e)(3)(B) of the Social Security Act.

Optional Waiver Coverage of Non-Medicare Aged, Blind and Disabled Individuals

Section 1115 waiver coverage is granted to certain non-Medicare entitled individuals who are aged, blind or disabled and have income at or below 135% of the federal poverty level. Coverage under the waiver is subject to an enrollment cap. Resource limits and other factors of eligibility apply, as determined by the Division of Medicaid.

Optional 1915 Waiver Coverage under Home & Community Based Services (HCBS)

The following is a list of waiver coverage offered by the Division of Medicaid. Eligibility for waiver participation is determined in full or in part by the Division of Medicaid, as noted. Waiver participants receive full Medicaid coverage plus additional waiver services that allow the individual to remain in a private living arrangement rather than a medical institution.

1. Elderly and Disabled (E&D) Waiver – is operated by the Division of Medicaid. This HCBS waiver includes aged or disabled individuals age 21 or older whose level of care has been certified using a preadmission screening tool. The aged or disabled individual must be eligible as SSI or qualify under an income level that is equal to the Medicaid institutional limit. Institutional income and resource limits and rules apply, including the use of an Income Trust to qualify for coverage. A waiver participant may not reside in a nursing facility or personal care home. The Division of Medicaid certifies eligibility for individuals who do not receive SSI.

2. Independent Living (IL) Waiver – is operated jointly by the Division of Medicaid and the MS Department of Rehabilitation Services. Eligibility is limited to individuals age 16 or older who exhibit severe orthopedic and/or neurological impairments. Clinical eligibility for waiver services is determined through a preadmission screening tool. An individual can participate in the IL waiver and be eligible as SSI, a Katie Beckett recipient, a Disabled Adult Child, a Working Disabled recipient or be eligible in a MAGI-related category or adoption assistance or foster child category of eligibility provided clinical waiver criteria is met. If an individual is not eligible in an allowed category, the individual may be determined eligible using institutional income and resource eligibility rules and limits, including the use of an Income Trust to qualify for coverage. The Division of Medicaid certifies eligibility for individuals who do not receive SSI or foster care/adoption assistance Medicaid through Child Protection Services.

3. Assisted Living (AL) Waiver – is operated by the Division of Medicaid. This HCBS waiver includes aged, blind or disabled individuals age 21 or over whose level of care has been certified by a preadmission screening tool. The individual must be eligible as SSI or qualify under the Medicaid institutional income limit. Institutional income and resource limits and rules apply, including the use of an Income Trust to qualify for coverage. Participants must reside in AL facilities that are approved to participate in the AL waiver.

4. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver – is operated jointly by the Division of Medicaid and the MS Department of Rehabilitation Services. TBI's and SCI's must meet certain conditions specified by the waiver and the extent of the injury must be certified by a physician. An individual can participate in the IL waiver and be eligible as SSI, a Katie Beckett recipient, a Disabled Adult Child, a Working Disabled recipient or be eligible in a MAGI-related category or adoption assistance or foster child category of eligibility provided clinical waiver criteria is met. If an individual is not eligible in an allowed category, the individual may be determined eligible by the Division of Medicaid using institutional income and resource eligibility rules and limits, including the use of an Income Trust to qualify for coverage. The Division of Medicaid certifies eligibility for individuals who do not receive SSI or foster care/adoption assistance Medicaid through Child Protection Services.

5. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver – is operated jointly with the MS Department of Mental Health as an alternative to institutionalization in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). This HCBS waiver carries no age restrictions and includes individuals eligible as SSI, a Katie Beckett recipient, a Disabled Adult Child, a Working Disabled recipient or eligible in a MAGI-related category or adoption assistance or foster child category of eligibility provided clinical waiver criteria is met. If an individual is not eligible in an allowed category, the individual may be determined eligible by the Division of Medicaid using institutional income and resource eligibility rules and limits, including the use of an Income Trust to qualify for coverage. The Division of Medicaid certifies eligibility

for individuals who do not receive SSI or foster care/adoption assistance Medicaid through Child Protection Services.

The Division of Medicaid offers 1915(i) State Plan services to individuals with an intellectual and/or developmental disability that need the services offered under 1915(i), specifically; day habilitation services, prevocational services and supported employment services. If a Medicaid recipient in a full services at-home category of eligibility has the clinical qualifications needed, the recipient can qualify for 1915(i) services without being placed on the ID/DD waiver program provided their income does not exceed 150% of the federal poverty level. Individuals enrolled in a Medicare cost-sharing group (QMB, SLMB or QI) or recipients in a full-service COE with income above 150% FPL can qualify for the 1915(i) services only by qualifying for the ID/DD waiver.

101.03 HOW TO APPLY

This chapter provides guidelines on the process of applying for eligibility determinations for all coverage groups.

101.03.01 APPLICANT

An applicant is someone whose signed application form has been received by the Division of Medicaid (DOM) and is requesting an eligibility determination. An applicant is also someone whose signed application is received by another agency or entity authorized to make Medicaid certifications.

An applicant includes someone who applies for coverage in MS through the Federally Facilitated Marketplace (FFM) and has their electronic application information transferred to DOM via a process referred to as an Account Transfer (AT).

101.03.01A DECEASED APPLICANTS

An application for Medicaid may be made on behalf of a deceased individual. The application must be filed before the end of the third month following the date of death for DOM to be able to consider the month of death for coverage, using the rules that apply for retroactive Medicaid.

101.03.01B NON-APPLICANTS

This is an individual who is not requesting an eligibility determination for himself or herself but is included in the applicant's household to determine eligibility for the applicant.

101.03.02 DOM APPLICATION FORM(S)

DOM uses three types of application forms to determine eligibility:

- For MAGI-related purposes, the Mississippi Application for Health Benefits is the single streamlined application form used to apply for Medicaid and CHIP. Information from this form is also used to refer individuals to the FFM for health coverage if ineligible for health coverage through DOM.For Family Planning purposes, the Application for Family Planning is the streamlined application form used to apply specifically for the Family Planning waiver program coverage.
- For ABD purposes, the Application for Mississippi Medicaid Aged, Blind and Disabled Medicaid Programs is used.
- The MAGI-related, Family Planning, and ABD applications forms may be a paper version, an electronic version, or an exact facsimile of the appropriate form.
- Applications filed for Medicaid coverage through other agencies or entities have their own Medicaid applications, such as CPS, SSI,HPE or PEP.
- The application form is a legal document, completed by the applicant or representative 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.

101.03.03 SIGNATURE REQUIREMENTS

An application form must be signed to be considered a valid application. The signature does not have to be an original signature since applications are allowed to be submitted via means other than on an original paper form; however, a valid signature by someone authorized to apply for Medicaid or CHIP is required. Signed and unsigned applications are treated differently, as specified below.

If an applicant is unable to write his/her name, the form may be signed with an "X" mark; however, a witness signature is required. If an applicant is incompetent (adjudged by a court) or incapacitated (due to a physical or mental condition), these conditions require that someone be named to officially represent the applicant, as addressed in "Representatives Authorized to Act for an Applicant."

- Unsigned applications and/or applications signed with a mark that are not witnessed must be returned to the applicant with an explanation of the signature requirements. An unsigned application or an "X" marked application that has not been witnessed is not valid.
- Applications that are signed but are incomplete are accepted as valid applications. The Specialist will work with the applicant to complete the information needed.
- Applications that are signed by an individual other than a person who is authorized to apply, as specified in "Who Can File" below, are accepted as valid applications. The Specialist must work with the applicant or head of household to obtain an acceptable signature on the submitted application form.

101.03.04 REPRESENTATIVES AUTHORIZED TO ACT FOR AN APPLICANT

There are three (3) types of representatives allowed to act on behalf of an applicant or recipient in filing an application for health coverage through DOM:

1. Authorized Representative

   An authorized representative is a person or employee of an organization who is acting responsibly for the applicant with his knowledge and written consent. The MAGI-related application form allows the head of household to designate an authorized representative with no separate written authorization required except in cases where the head of household has a legal representative who is required to act on his/her behalf. ABD applications require the use of a separate authorization form (DOM-302A) for an applicant or recipient to appoint an authorized representative. The authorized representative has knowledge of the applicant's circumstances and is usually a relative or close friend but may be a designee of an organization if the applicant or recipient permits. 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 and receive all eligibility notices; however, the applicant or recipient has the right to limit the authority of their authorized representative. The appointment of an authorized representative does not prevent the Division of Medicaid from communicating directly with the applicant or recipient as deemed appropriate.

   NOTE: In instances where the applicant or recipient designates an authorized representative but places a limit on the receipt of notices by the representative, maintain the authorized representative information in the case record rather than entering the representative information in the system. If representative information is entered into the system, the representative will receive all letters and notices issued by the system.

   When an organization or other individual assisted with the completion of an application and their primary need is access to case record information rather than function as a case representative, completion of the "Authorization for the Use/Disclosure of Protected Health Information" form may be more appropriate to allow access to information while the applicant or recipient represents themselves. Contact with the applicant

or recipient is needed to make this determination, which must be documented in the case record.

2. Self-Designated Representative

A self-designated representative is a person acting responsibly for an applicant or recipient because the physical or mental condition of the applicant/recipient is such that he cannot authorize anyone to act for him nor can he act for himself. Family members or non-relatives with knowledge of the applicant's or recipient's circumstances are allowed to self-designate in writing with the use of a form designed for this purpose (DOM-302B). A representative of an organization or a provider cannot self-designate to represent an applicant or recipient, except in cases where the self-designating individual is an owner, operator or employee of a state-owned long term care healthcare facility. All other individuals representing an organization or provider must become legally appointed to represent an individual for health care decisions, in which case the individual becomes the Legal Representative of the applicant or recipient.

A self-designated representative must file an application or review form in the name of the applicant/recipient with the self-designated representative providing required information to determine or re-determine eligibility and sign all eligibility-related forms that are required. The self-designated representative will receive all eligibility notices and letters.

NOTE: A parent or primary caretaker relative is allowed to apply for a child without signing the self-designation form authorizing themselves as a representative.

3. Legal Representative

A legal representative is someone who has been legally appointed to act on behalf of an applicant or representative. The legal representative must provide documentation of their legal authorization to act for the applicant or recipient, such as a Power of Attorney document, legal guardianship decree, conservatorship decree, a custody decree or other type of court order, and complete a Legal Representative form (DOM-302C). All such documents must specify that the legally appointed individual has the right to make health care decisions for the applicant

or recipient. If an applicant or recipient is deceased, proof that the individual is the executor or administrator of the applicant's or recipient's estate is required if eligibility is needed in the month of death and/or retroactive period. The legally appointed representative will act on behalf of the applicant or recipient in all matters with the Division of Medicaid without limitation.

101.03.05 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 with 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 caretaker relative with whom a dependent child is living who has primary responsibility for the child's care.
    - A caretaker relative is a relative by blood, adoption or marriage with whom the child is living who assumes primary responsibility for the child's care.
    - A dependent child is under the age of 18 and deprived of parental support by reason of death, absence from the home or physical or mental incapacity.
- An authorized representative designated in writing by the applicant on the MAGI application or on DOM-302A, Authorized Representative Form, for ABD;
- A self-designated representative who signs the appropriate DOM-302B, Self-Designated Representative Form, allowing self-designation.

- A legal representative with the authority to make healthcare decisions for the applicant who has completed Form 302C, Legal Representative Form.

An application signed by anyone other than a person described above will be accepted, but a signature of a person authorized to apply must be obtained during the application process.

101.03.06 ACCESS AND ACCOMMODATION IN APPLYING

Access to a regional office or out-stationed site should not be a barrier for individuals wishing to apply in person or request assistance with the application process. Each office where Medicaid Specialists are located must be accessible for handicapped persons. If a site is not accessible, make alternate accommodations, including assistance with an alternative method of filing the application.

Each application intake site and each telephone application are required to accommodate:

- Individuals with limited English proficiency, i.e., individuals who are unable to communicate effectively in any language other than his native language. When interpreter services are needed, use DOM's language and document translation service 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. This service is available free of charge and is available to applicants and those inquiring about coverage, or services offered through DOM. The individual's privacy must always be protected during such calls. It is not permissible to require an applicant to provide his/her own interpreter or rely on an accompanying adult or minor child of the applicant to provide interpreter services unless it is an emergency involving imminent threat of safety or welfare of the applicant or recipient or person inquiring, and no qualified interpreter is available. However, if the applicant, recipient or individual inquiring about Medicaid requests an accompanying adult to interpret and the adult agrees and reliance on the adult is appropriate to the circumstances, DOM may allow the adult to provide interpreter services.

- Blind applicants by reading forms in their entirety, assist in completion of the forms, explain various program requirements and services offered through the agency and answer any questions the applicant may ask.
- Deaf applicants by securing a person proficient in sign language when needed or communicate in writing to relate an explanation of program requirements and services offered through the agency and to answer questions.
- Individuals who cannot read and/or write by reading forms in their entirety, assist in completion of the forms, explain various program requirements and services offered through the agency and answer any questions the applicant may ask.

101.03.07 REASONABLE EFFORTS TO ASSIST

The Regional and Central Office of DOM is expected to:

- Provide orderly surroundings to persons who come to the office;
- Provide courteous service to all persons who come to or contact the office;
- Provide the appropriate application form to anyone who requests one;
- Allow any individual the right to apply for any benefits, regardless of circumstances. This includes allowing a clearly ineligible individual to apply;
- Communicate in a clear and courteous manner information regarding programs and services offered through DOM;
- Determine 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.

In addition, it is required that Medicaid Specialists make reasonable efforts to assist all applicants to have the applicant's eligibility determined and/or re-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.

MAGI and/or ABD applicants who ask for assistance or are not capable of handling the application process and have no available family member or friend capable of assisting or have representatives who do not act responsibly for a MAGI or ABD applicant require special handling. Otherwise, the application will result in multiple denials that must be avoided if agency intervention is needed to resolve a failure to comply with application or renewal processing. Action needed is as follows:

- If the application is for long term care in a nursing facility, the Specialist assigned to the nursing facility should contact the facility to let appropriate staff know that the application cannot proceed because the representative is not cooperating, or the applicant is not capable.
  If the facility is a state-owned or operated facility, the administrator or his/her designee can act as a self-designated representative if there is no available family member that can become the representative. For privately owned facilities, the administrator has the right to become the legal representative to act for the applicant unless another family member is available. If the administrator is willing to become the legal representative, pend the case until the legal authority can be obtained. If the applicant already has a court-appointed legal representative, the nursing facility (or other available family member) has the right to approach the court to have a non-cooperating legal representative removed and replaced with someone willing to act responsibly.
- If the application or review is for an at-home ABD or MAGI-related case, the Specialist must speak with the applicant to determine if there is a family member or close friend or neighbor that would be willing to assist the individual in becoming an authorized representative to secure any needed verifications.
- If an applicant (MAGI or ABD, at home or in long term care) already has a legal representative appointed as Power of Attorney but the individual is not cooperating in the application process, the Specialist should discuss this matter with other available family members who may be

willing to secure Power of Attorney. The most recently appointed Power of Attorney with the right to make healthcare decisions for the applicant will be the one with the authority to act for the applicant.

- If any of the above situations does not address or remedy a situation where an applicant/recipient is incapable or unable to provide needed information and there is either no representative or there is an irresponsible representative who is not acting in the applicant's best interest, the Specialist must discuss the situation with their supervisor who should seek assistance from their central office contact.

101.04 FILING THE APPLICATION

Individuals inquiring about program eligibility requirements should be informed of their opportunity to apply and informed about the various means of applying. If a hardcopy 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, the individual will be contacted, if possible, and the various means of applying explained. Otherwise, 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.

The agency must allow an individual or individuals of an applicant's choice to accompany and assist an applicant or recipient in the application or redetermination process; however, to officially represent the applicant or recipient, an individual must become an authorized, self-designated or legal representative. Refer to 101.03.04 for a discussion of authorized representatives and individuals or organizations needing access to case information, in which case the HIPAA release form may be more appropriate.

101.04.02 REQUEST FOR AN INFORMAL MEDICAID ELIGIBILITY OPINION

An individual seeking assistance from other social service agencies may be required to obtain a statement from DOM advising that he is not eligible for Medicaid 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. The "Request for Unofficial Denial" form is in the Appendix page by the same name and must be used to issue an unofficial denial of eligibility.

101.04.03 SUBMITTING AN APPLICATION AND APPLICATION FILE DATE

An application for Medicaid may be filed in any of the following described submission methods. The application file date is the date a valid application form is received by the agency:

- 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. The filing date is the date received by the office or other location.
- 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 in any regional office. The filing date is the date received by the agency (central or regional office, whichever office first receives the application). An original signature is not required,
- By on-line submission of the application to DOM. The filing date is the date received by the agency (central or regional office). An electronic signature is accepted for applications filed on-line with the agency.

- By on-line submission of the application through Common Web Portal. The filing date is the date received by the agency (central or regional office). An electronic signature is accepted for applications filed on-line with the Common Web Portal.
- By on-line submission of the application to the Federally Facilitated Marketplace (FFM), which is then transferred to DOM. The filing date is the date the application is received by the FFM. An electronic signature is accepted for applications filed on-line through the FFM.
- By telephone via a telephonically recorded application process. By telephone via a telephonically recorded application process. The date of filing is the date the telephonic signature is recorded, which should be the date of the telephone interview. Telephone applications are conducted by Medicaid office staff completing the appropriate paper application based on applicant statements that are recorded, including the telephonic signature. A request for a telephonic application received by central office or regional office staff must be coordinated for the interview to be recorded. Upon request, office staff will schedule the telephone interview with the applicant. ABD telephone applications may be accepted by a regional office when circumstances prevent the applicant from applying or being interviewed in any other manner. The date of the telephone interview is the date of filing. The telephonic signature must be recorded.

Once a signed and dated application has been received by the agency, it must not be altered by adding, changing or deleting any information. During an interview, an applicant may make changes to the information on an application. If the interview is in-person, the applicant must initial the changes. If the change to information on the application is reported in any other manner, it must be documented in the case record and/or in the case narrative, but not on the application form.

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 a MAGI-related 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 program lines to determine if eligibility exists under any category of Medicaid coverage. For example, a MAGI-related application indicates an applying household member is disabled. If the disabled member of the household is not eligible in a MAGI-related category, an ABD application would be issued as a supplemental form as outlined in 101.09, Combination MAGI and ABD Applications. The MAGI-related application date is the protected filing date.

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.

101.04.05 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.

101.04.06 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.

101.04.07 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, determine if eligibility can be established for the month of application or any subsequent month(s) when the applicant lived in MS.

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.

101.04.08 WHERE TO FILE THE APPLICATION

Applications should be filed with or directed to 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:

Application Filed with Correct RO	Date stamp the form if received as a hard copy. Register the application within 48 hours (certain applications are auto registered, such as Account Transfers from the FFM or LIS applications from SSA). Also, scan and upload the application, and any other documents provided, to the appropriate folders in MEDS under case documents.	If ABD application received in-person for coverage groups requiring telephonic interview, conduct interview if possible If interview cannot take place, or if application received by mail or electronically, schedule required telephonic interview in writing within 10 calendar days of receipt of application. MAGI applicants applying in person must be offered assistance, if requested.
Application Filed with Incorrect RO	Accept the application and date stamp; Register the application with the appropriate county and RO within 48 hours of receipt. Also, scan and upload the application and any other documents provided to the appropriate folders in MEDS under case documents. Applications that are auto registered (CWP/FFM/LIS) in the wrong RO should be transferred within 48 hours of receipt. All applications that are not transferred within 7 days or applications for which a 307 has	If ABD application received in-person for coverage groups requiring telephonic interview, conduct interview, if possible; offer assistance to MAGI applicants, if requested. Inform the applicant of the RO that will handle the case.

	already been issued should not be transferred until after the case is completed.	

Combination ABD/MAGI Households

Combination ABD/MAGI households are defined as cases in which there is both an ABD applicant or recipient living in the same household as MAGI applicants or recipients. ABD and MAGI individuals living in the same household are treated as one case in the system and one record is created, with the person designated as the head of household as the primary case head. The regional office that serves the household's county of residence is the office responsible for the ABD/MAGI members, regardless of where the application is filed or whether the ABD and MAGI applications are filed at the same time or separately.

If an ABD applicant/recipient is institutionalized which causes other ABD/MAGI applicants or recipients to live apart from the institutionalized individual but the household remains bound by relationship (marriage, parent/child), two separate cases are set up in the system; one for the at-home household members and one for the institutionalized member. One case record is established with the person who is the head of household of the ABD institutionalized case as the primary case head. The regional office that serves the county where the nursing facility is located is responsible for both ABD and MAGI cases

Applications Filed with the Federally Facilitated Marketplace (FFM)

Applications for MAGI-related Medicaid or CHIP may also be filed on-line with the Federally Facilitated Marketplace or FFM. The FFM is also referred to as the health insurance exchange. An FFM operates in states that choose not to build their own state-operated exchange. The FFM for MS determines eligibility for enrollment in qualified health plans and insurance affordability programs and assists in determining eligibility for Medicaid and CHIP by verifying certain application information through a Data Services Hub. If an individual or family appears to be eligible for Medicaid or CHIP based on Hub verified data, the FFM transfers the electronic account, referred to as an Account Transfer, to MS for completion of the application.

- An individual who applies for Medicaid coverage in MS through the FFM has their electronic application information transferred to DOM via a process referred to as an Account Transfer (AT).

- AT's received from the FFM are evaluated for MAGI-related coverage initially but if any household member indicates on the AT that a disability exists or if the individual is aged, that household member is evaluated for ABD coverage.
- The "insurance affordability program" referenced above is a term that includes Medicaid, CHIP and coverage in a qualified health plan through the FFM that provides advance payments of a premium tax credit or cost-sharing reductions to qualified individuals.
- MAGI-related denials that do not indicate possible ABD eligibility are automatically referred to the FFM for an evaluation of coverage in other insurance affordability programs. Non-Medicare ABD denials are also referred to the FFM for an evaluation of coverage. NOTE: Referrals to the FFM are made upon denial provided the application is not denied for administrative reasons, such as, failure to comply with application requirements, voluntary withdrawal or any other denial due to failure to complete the application process.

101.04.09 VOTER REGISTRATION

The National Voter Registration Act (NVRA) requires the Division of Medicaid, as a public assistance agency, to offer the opportunity to register to vote or update voter registration to applicants, recipients and adults applying for

children at the time of application and at review and whenever an address change is reported. Each regional office must ensure the voter registration form entitled, "Mississippi Mail-In and NVRA Agency Voter Registration Application" form are included with application forms mailed or given out for an applicant to complete, and available during in-person interviews within the office and at out-stationed sites. Voter registration forms are also available on-line for applicants applying online. Voter registration forms must also be offered to individuals applying by telephone. Assistance with completion of the forms must be offered and provided unless assistance is refused. It is not required for the agency to offer voter registration forms/assistance to a representative of an adult.

The MAGI-related application form asks if the applicant wants to register to vote. The ABD application form refers the applicant to their worker if the applicant wants to register to vote or update their voter registration information. Responses to these questions are entered into the system for reporting purposes.

Voter registration forms completed and returned to the regional office must be logged on the appropriate form and transmitted to the appropriate county Circuit Clerk's office with 5 business days of receipt. Form received within 5 days of the voter registration deadline must be transmitted daily.

The agency offers voter registration training for new employees and existing employees are trained in the specifics of voter registration responsibilities semi-annually.

101.05 MEDICAID APPLICATIONS FILED THROUGH ANOTHER AGENCY OR ENTITY

Certain applications for Medicaid are filed through other agencies or entities. Currently, these include the following types of applications that are discussed in further detail below.

- SSI applications. SSI applicants approved for SSI are automatically eligible for Medicaid with no separate application for Medicaid required unless retroactive Medicaid is needed or there are missing months of SSI eligibility that need to be evaluated for Medicaid-only eligibility to fill in gaps of ineligibility for SSI. In addition, SSI recipients entering long term

care in a nursing facility, ICF/IID or PRTF require DOM authorization of a Medicaid per diem payment to the facility.

- Children under age 21 who are in the custody of the Department of Child Protection Services (DCPS) and who are certified as Medicaid eligible by the DCPS. Foster children and adoption assistance children determined eligible for Medicaid by DCPS require no separate application. If the individual enters a nursing facility, ICF/IID or PRTF, DOM must authorize the Medicaid per diem payment to the facility.
- Applications filed with the FFM and transferred to the Division of Medicaid as Account Transfers (AT's). Referrals from the FFM require a decision to approve or deny eligibility for Medicaid or CHIP from DOM.
- Applications submitted by individuals through the Common Web Portal (CWP) are loaded directly into MEDS to be processed by the Division of Medicaid. Applications from the CWP require a decision to approve or deny eligibility for Medicaid or CHIP from DOM.
- LIS (Low-Income Subsidy) applications filed as part of an application for Medicare coverage through the Social Security Administration (SSA). LIS applications are applications whose eligibility is limited to one of the Medicare cost-sharing coverage groups (QMB, SLMB or QI) and require a DOM decision to approve or deny eligibility.
- Hospital Presumptive Eligibility (HPE) applications processed by qualified hospitals to certify and place time-limited Medicaid eligibility on file for individuals qualifying for HPE. HPE eligibility is determined by qualified hospital staff.
- Presumptive Eligibility for Pregnant Women (PEP) applications processed by qualified providers/entities to certify and place time-limited Medicaid eligibility on file for individuals qualifying for PEP. PEP eligibility is determined by qualified provider/entity staff.

101.05.01 APPLICATIONS FOR SSI APPLICANTS

SSI applicants who file an application with SSA will automatically receive Medicaid for months SSI is approved. A systems-generated notice of Medicaid approval is issued by DOM providing the beginning date of SSI/Medicaid eligibility and informing the SSI recipient that retroactive Medicaid is available. The notice provides the name, address and phone number of the Medicaid

Regional Office where a retroactive Medicaid application may be filed. This notice is separate from the SSI notice of approval.

SSI applicants who are denied SSI receive a systems-generated notice of Medicaid denial issued by DOM explaining that although SSI/Medicaid is denied, eligibility for Medicaid-only is available. The various ABD coverage groups are described in the notice and so is the availability of retroactive Medicaid. The notice provides the name, address and phone number of the Medicaid Regional Office where a retroactive Medicaid and/or Medicaid-only application may be filed. This notice is separate from the SSI notice of denial.

An SSI applicant may apply for SSI and for Medicaid-only with DOM on the same date or for the same time period. When an application is filed for both SSI and for Medicaid-only, a decision is required by DOM on the Medicaid application. It is not appropriate to hold the application while waiting on the SSI decision nor is it appropriate to deny the application because the applicant has an application pending with SSA. If retroactive Medicaid is requested, a Medicaid decision on the retroactive month(s) is required regardless of whether the SSI application is approved or denied.

Follow policy outlined in 101.10.06 for SSI Eligibles requesting retroactive Medicaid and/or eligibility for missing month(s) of SSI eligibility.

Follow policy outlined in 500.10.01 for SSI Eligibles entering Long Term Care who need the LTC per diem payment authorized by DOM.

101.05.02 APPLICATIONS FOR FOSTER CHILDREN AND ADOPTION ASSISTANCE CHILDREN CERTIFIED BY THE DEPARTMENT OF CHILD PROTECTION SERVICES (DCPS)

Children who qualify for Medicaid while in the custody of DCPS are certified as Medicaid-eligible by DCPS, including any retroactive months. However, not all children in the custody of DCPS are eligible for DCPS-related Medicaid, usually because the child has income (or resources) of their own that exceeds the limit(s) allowed by DCPS. If a child is not Medicaid eligible through the DCPS, the county Social Worker or foster parent will apply for Medicaid for the child through the Medicaid Regional Office and the RO will handle as a MAGI-related

application, unless the child applies based on disability and ABD Medicaid is requested.

Follow policy outlined in 500.10.02 for foster children or adoption assistance children certified as eligible by DCPS entering Long Term Care who need the LTC per diem payment authorized by DOM.

101.05.03 ACCOUNT TRANSFERS (AT'S) RECEIVED FROM THE FFM

Individuals who apply for health coverage through the FFM are assessed for Medicaid and CHIP eligibility and health coverage through the FFM. If some or all household members appear to be Medicaid or CHIP eligible, the electronic accounts for those household members are transferred to DOM. If some or all household members are not eligible for Medicaid or CHIP but are eligible for health coverage through the FFM through a participating health insurer, those individuals are enrolled in a Qualified Health Plan (QHP) by the FFM. Individuals who are enrolled in a QHP with income between 100% - 400% of the FPL based on family size can qualify for premium credits to purchase insurance or for cost-sharing subsidies that reduce annual cost-sharing expenses of the insurance purchased through the FFM.

Individuals referred for Medicaid or CHIP coverage are first evaluated by the system to determine the following:

- If there is sufficient information on the AT file to identify household members and confirm that applying household members are not currently eligible in any active case, the case is auto registered in the system as a pending application. Sufficient information includes an SSN for all applying.
- When an AT is received on a non-qualified non-citizen, determine if individual has received an emergency medical service in the application month or prior three months. The FFM assesses the individual for eligibility but not for an emergency service.
- If a household member or entire case is closed in the system, the individual or case will have an application contact opened so that an application can be processed for the applying household members.
- If an AT lacks sufficient identifying information to auto-register an application or redetermination contact, the AT defaults to a pdf

document on Report RJ564. This report is used by the regional office to register the application in the system and is loaded into the electronic record in MEDS.

The regional office assigned the AT will complete the application in the same manner as an application received by DOM.

101.05.04 APPLICATIONS RECEIVED FROM THE COMMON WEB PORTAL (CWP)

The Common Web Portal is a common application form shared with DHS. An individual can apply for SNAP, TANF, and/or Medicaid. Applications filed through the Common Web Portal for health benefits are assessed for Medicaid and CHIP eligibility. If a CWP application lacks sufficient information to auto-register an application or redetermination contact, the CWP form defaults to a pdf document on Report RJ568. This report is used by the regional office to register the application and is loaded into the electronic record in MEDS.

101.05.05 LOW INCOME SUBSIDY (LIS) APPLICATIONS RECEIVED FROM SSA

For individuals who apply for the Low-Income Subsidy (LIS) with the Social Security Administration (SSA), the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires SSA to forward an electronic application to the state Medicaid agency to determine if the individual is eligible in a Medicare Savings Program (referred to by DOM as Medicare Cost-Sharing programs, consisting of QMB, SLMB and QI). An individual indicates their desire to apply for eligibility to be determined under the Medicare cost-sharing programs when applying for Medicare and/or Social Security benefits and checking “yes” to the question that asks about applying for “Extra Help” in paying for Medicare expenses. Electronic applications are received daily from SSA.

When the electronic application is received by DOM, the following occurs:

- The system checks the recipient file to determine if the individual is currently eligible for Medicaid. If the individual is eligible, the LIS application is placed on a report in Reports On-Line that indicates the LIS application was not registered because the individual was eligible for Medicaid.
- If the individual is not currently eligible, the system registers a pending LIS application.
- Each regional office must complete their assigned LIS applications by first reviewing the information submitted by SSA on the LIS file. Accept the attested information on the LIS application without further verification and approve the applicant unless:
    - the income attested on the application is over the income limit; or
    - the worker is aware of information that is not compatible with the attestation.
- If additional information is needed to make a decision on income eligibility, issue applicable Request(s) for Information to secure the needed verification to approve or deny the LIS application.

101.05.06 HOSPITAL PRESUMPTIVE ELIGIBILTY (HPE)

Qualified hospitals are allowed to make presumptive eligibility decisions prior to a formal determination of Medicaid eligibility by the Division of Medicaid. A qualified hospital is one that participates as a Medicaid provider, has executed required HPE formal agreements with DOM and agrees to make HPE decisions according to state policies provided to authorized hospital staff. HPE is time-limited Medicaid eligibility for certain children, pregnant women, parents or caretakers presumed to be eligible for Medicaid.

DOM provides qualified hospitals with the HPE application form and model notices to use to establish HPE. The hospital must provide written notice to the HPE applicant regarding their eligibility for HPE and assist the HPE applicant in completing and submitting the full application for Medicaid before the end of the HPE period.

The Division of Medicaid provides training and training material to hospital staff assigned to HPE. These individuals are required to pass a knowledge test before becoming certified to authorize HPE decisions. In addition, DOM provides the HPE staff with HPE applications and notices for use in HPE decisions. HPE approvals must be transmitted by the qualified hospital to DOM central office staff assigned to HPE within 5 days after the approval decision. DOM assigns a Medicaid ID and places HPE on file.

The begin date of HPE is the day the hospital approves HPE. The end date of HPE is either the last day of the month following the month the HPE period begins, or the day DOM makes the final decision on the full application, which could either lengthen or shorten the HPE period.

If a full Medicaid application is submitted to DOM following the HPE decision, the application is auto assigned to the appropriate regional office, but the application is completed by the central office staff member assigned to HPE. If the application is approved, the regional office is responsible for the case after approval, i.e., at the time of the first renewal or reported change. If the full application is denied, identifying information remains on record with the office in the event the individual reapplies.

101.05.07 PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN (PEP)

Qualified providers/entities are allowed to make presumptive eligibility decisions prior to a formal determination of Medicaid eligibility by the Division of Medicaid. A qualified provider/entity is one that participates as a Medicaid provider, has executed required PEP formal agreements with DOM and agrees to make PEP decisions according to state policies provided to authorized entity staff. PEP is time-limited Medicaid eligibility for pregnant women presumed to be eligible for Medicaid.

DOM provides qualified providers/entities with the PEP application form and model notices to use to establish PEP. The provider/entity must provide written notice to the PEP applicant regarding their eligibility for PEP and assist the PEP applicant in completing and submitting the full application for Medicaid before the end of the PEP period.

The Division of Medicaid provides training and training material to provider/entity staff assigned to PEP. These individuals are required to pass a knowledge test before becoming certified to authorize PEP decisions. In addition, DOM provides the PEP staff with PEP applications and notices for use in PEP decisions. PEP approvals must be transmitted by the qualified provider/entity to DOM central office staff assigned to PEP within 5 days after the approval decision. DOM assigns a Medicaid ID and places PEP on file.

The begin date of PEP is the day the provider/entity approves PEP. The end date of PEP is either the last day of the month following the month the PEP period begins, or the day DOM makes the final decision on the full application, which could either lengthen or shorten the PEP period.

If a full Medicaid application is submitted to DOM following the PEP decision, the application is completed by the central office staff member assigned to PEP. If the full application is approved, the regional office is responsible for the case after approval, i.e., at the time of the first renewal or reported change. If the full application is denied, identifying information remains on record with the office in the event the individual reapplies.

101.06 INTERVIEWS WITH DOM

Interviews are required for all long-term care (institutional) ABD programs with an asset test. The interview can be conducted in person if the applicant or applicant's authorized representative applies in person or requests an in-person interview. For all other instances, the interview requirement will be met by a telephone interview. Required interview discussions include provisions specific to ABD that are applicable to the applicant's case that are listed below. If a specific ABD provision is not discussed during the interview because it was not relevant at the time, contact with the applicant or their representative must be attempted by telephone to discuss the matter. For example: at the time of the interview, it was not known that the applicant needed a Long-Term Care Income Trust in order to qualify. Although a LTC Income Trust document and Help

Sheet must be issued to the responsible person via DOM-307, contact with the applicant or representative is also required to explain Income Trust rules. Informing the individual is critical in order for the individual to make an informed choice regarding their eligibility since delaying eligibility is an option as outlined in 304.05.04. Failure to discuss can result in financial hardship and/or unnecessary eligibility issues. Interviews conducted must be documented.

Although in-person interviews are not required for any application or renewal, an applicant may request assistance with completing an application either in-person or by telephone. When assistance is requested, include all relevant information described in the "Interview Discussion" described below. Whenever an applicant requests an in-person interview, one will be conducted even if the program does not require an interview.

101.06.01 INTERVIEW DISCUSSION

In general, during an interview for ABD or MAGI-related applications, the specialist reviews:

- Household composition and relationships to explain the individuals who are required to be included in the application and/or budgetary process and those who cannot be included.
- The specific programs and services available to the applicant and/or family through the Division of Medicaid, such as non-emergency transportation for individuals eligible for full Medicaid.
- Services offered by other agencies with referrals made, as appropriate.

The following policy provisions are required for both ABD and MAGI interviews:

Provision	Required Discussion Points
Filing an application	The agency must allow individual(s) of the applicant's choice to accompany and assist the applicant in the application or review process.
Coverage groups	Eligibility requirements for the coverage group(s) the applicant appears potentially eligible in must be explained.

Provision	Required Discussion Points
Coverage limited to one source	Coverage is limited to only one source of eligibility. If the individual is eligible under another source, that source must terminate before ABD or MAGI-related eligibility begins.
Purpose of application	The use and purpose of the application, including that the applicant is agreeing to all the rights and responsibilities specified on the application by signing the form.
Processing limits	The applicable Standards of Promptness (SOP).
Conditions of eligibility	Discuss critical factors such as age or disability, providing a SSN, citizenship or alien status, assignment of rights, who is authorized to sign the application or act on behalf of the applicant and other factors as applicable as the application is completed or reviewed.
QC reviews	The Quality Control review process.
Computer matching	The use of Social Security Numbers in computer matching programs.
Appeals	Rights to a fair hearing for adverse actions, exceeding SOP, erroneous actions.
Covered services	Available services such as the EPSDT program and the annual physical for adults.
Verification of eligibility	Verification requirements and methods to be used to establish eligibility, including the use of electronic databases, collateral contacts, and documentary verification.
Reporting changes	The change reporting requirements.
Voter registration	Voter registration opportunities.
Managed care	Enrollment in MississippiCAN for mandatory populations.

The following explanations are specific to ABD institutional applications (LTC and HCBS) and must be addressed as applicable:

Provision	Required Discussion Points
Estate Recovery	Estate recovery as it applies to excluded resources, such as the home or income producing property. Provide copy of Estate Recovery Fact Sheet from DOM website.
Income Trust	If applicable, provide copy of LTC or HCBS Income Trust document and repayment requirements, either through payment of Medicaid Income or direct payment to DOM of overage or both. If payment is due for month of entry for LTC, explain option to delay Medicaid coverage to following month to avoid payment of amount that is above the institutional limit. Discuss setting up a separate bank account for funding HCBS & if applicable, LTC IT's.
Annuities	If applicable, provide copy of ABD handout on annuities and discuss verification and annuity requirements, such as making DOM the beneficiary of the annuity if required.
Transfer of Assets	Discuss prohibition of transfer of assets within 5-year lookback period and as an ongoing prohibition. Provide the ABD Transfer of Assets handout to all institutional applications (LTC & HCBS).
Asset Verification System (AVS)	Explain the authorization for financial institutions to disclose financial account information is a condition of eligibility (AVS matching).
Spousal resource & income rules	If applicable, discuss spousal impoverishment rules and provide a copy of the Spousal Resource and Income Rules handout. Discuss the 90-day period for transferring assets to the CS subject to the CS limit. Assets over the spousal limit are considered available to the IS. Discuss the spousal income allocation.
PAS and 317 forms from NF	For LTC applicants, explain the requirement for medical necessity of the NF placement and that forms submitted by the NF will document the level of care requirement.
Post-eligibility	For LTC applicants, discuss Medicaid Income requirements including income used in the Medicaid Income calculation (counting lump sum payments and averaging income that varies or is infrequent). Explain deductions such as the Personal Needs Allowance, CS and/or other family member deduction, and the allowance of non-covered medical expenses and the need to timely submit any out-of-pocket expenses. Determine if allowable pre-eligibility expenses need to be submitted.
Miscellaneous	Discuss any other provisions applicable to the case, such as: Medicare covered days, Substantial Home Equity disqualification period, the 30-consecutive day requirement and any other provisions as applicable.

The following explanations are specific to ABD at-home cases:

Provision	Required Discussion Points
Deeming of income & resources from a spouse	If applicable, deeming of income and resources from an ineligible (non-applying) spouse to an eligible spouse is required, if living together. Higher couple need standards are then used to determine eligibility (couple FPL or FBR and couple resource limit).
Deeming of income & resources from parent to child	If applicable, deeming of income and resources from ineligible (non-applying) parent(s) to an eligible child or eligible children is required, if living together. The exception is deeming from a stepparent to a stepchild. The parent(s) income is subject to certain deductions (allocating to ineligible children, a living allowance, etc.) prior to deeming to the child or children. Resources of the parent(s) are also subject to a reduction before deeming.
Asset Verification System (AVS)	Explain the authorization for financial institutions to disclose financial account information is a condition of eligibility (AVS matching). If accounts cannot be verified electronically, the applicant must provide the needed verification.
Verification of income & resources	Explain that income & resources will be verified electronically to the extent possible. Income and resources that cannot be verified electronically must be verified through other means. Income and resources of the spouse or parent(s) must also be verified.
Deductions from income	Explain income deductions for at-home budgeting (student earned income deduction, impairment related work expense(s), excluded income) for at-home budgeting.

The following explanations are specific to MAGI-related applications and must be addressed if the MAGI applicant requests assistance in completing the application:

Provision	Required Discussion Points
Children's eligibility	All possibilities for Medicaid eligibility must be tested before considering CHIP eligibility. Children who qualify for Medicaid cannot be approved for CHIP.
	The income of a stepparent living in the home with applicant children must be considered toward the children's eligibility.

Parent or Caretaker Eligibility	Child Support cooperation requirements and income of an applicant's spouse must be considered toward the applicant's eligibility, unless the spouse receives SSI. A spouse can qualify for Medicaid eligibility as a 2-parent household or caretaker/spouse household.
Verifications	Requested verifications must be provided for each person included in the budgeting process if the verification cannot be obtained through available data sources. Failure to provide information may result in individual or multiple denials, depending on the program or type of verification which is lacking. Income is verified electronically to the extent possible but if not possible, the head of household is responsible for securing the needed verifications.
Non-applicants	Verification of personal information, income and expenses is not needed for household members who are not included in the budgeting process.
Non-countable assets	Resources are not considered & non-taxable income is not counted.

101.06.02 CONCLUDING THE INTERVIEW

At the conclusion of the interview, the applicant or his representative must understand 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.
- Notifications required, including a written notice of approval and the issuance of Medicaid or CHIP cards or a denial notice 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.

101.07 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.

101.07.01 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.

101.07.02 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.
- A disability decision has not been returned by DDS.
- Administrative or other emergency delay that could not be controlled by the 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.

101.07.03 ABD STANDARDS OF PROMPTNESS

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 issued to the applicant. When there is a delay, the reason must be documented in the record.

101.07.04 MAGI-RELATED STANDARD OF PROMPTNESS

MAGI-related programs have a 45-day standard of promptness. No more than 45 days may lapse from the date an application is filed to the date the notice of decision is issued to the applicant. Any delays in processing MAGI-related applications must be client-caused or requested. When there is a delay, the reason must be documented in the record.

NOTE: For MAGI applications filed with the FFM, the date of application is the date it is filed with the FFM; however, the standard of promptness begins when the application is received by DOM.

101.08 PROCESSING 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 correct case documents folder within MEDS.

As part of the eligibility process, information provided by the applicant, secured through electronic data bases and obtained from other sources must be verified, documented, and evaluated by the specialist prior to making the eligibility decision.

If information provided by or on behalf of an applicant on the application form is consistent with information obtained through electronic data sources, eligibility must be determined based on such information. An applicant must not be required to provide additional verification or documentation unless needed information cannot be obtained electronically or the information obtained electronically is not consistent with information declared on the application or otherwise secured during the application process.

101.08.01 MAKING AN ELIGIBILITY DECISION

Eligibility decisions are made using the following:

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

  Verification is obtained using electronic data sources or by information provided by the applicant. The specialist will accept reasonable documentary verification provided by the applicant and will be primarily concerned with how adequately the verification proves the statements on the application form. Only information material to the applicant's eligibility is subject to verification, through electronic means or otherwise.

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

- Documentation - 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 electronic data sources, the 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 case narrative must also show why the statement of the applicant or beneficiary is reasonable and acceptable.

NOTE: For MAGI applicants who attest on the application form that one or more household members receive income that does not count (such as SSI, TANF, VA benefits, Workers' Compensation, Child Support), consider this as documentation of income available to support the family. In other words, the household is not a $0 income household but rather a household sustained by income that does not count. If the application form has no mention of receipt of non-countable income and there is no declared income or resources, the case narrative must contain a reasonable explanation of how the household is meeting basic needs.

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 case narrative must show an appropriate request(s) was issued to the applicant.

- Evaluation –Information provided by the applicant or obtained through electronic data sources or 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 narrative should specify which source was accepted and why. The final determination of eligibility is made based on the most reliable source available.

101.08.02 USE OF COLLATERAL CONTACTS

If needed verification is not available from an electronic data source, the applicant is generally the source used to supply needed verification. However, at times information may also be obtained directly from third parties.

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 or a copy of signature page of the ABD application form that contains the Release of Information authorization by the applicant. 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 electronic data sources and other federal or state benefit information that is available to the agency.

101.08.03 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 verification from electronic data sources is not available or is inconsistent with applicant provided statements.

When additional information is needed, the following action is taken:

ABD Applicants	MAGI-Related Applicants
Issue DOM-307, Request for Information, to take a necessary action to request specific information that must be provided based on the ABD application responses. Request only needed verification and required actions; do not request information that does not apply.	**Direct contact** must be attempted before issuing a written request for information when information from electronic data sources conflicts with information provided on the MAGI application. If a reasonable explanation is provided, document the contact in the case narrative. If direct contact is unsuccessful, document each attempted

	contact and issue written notice as described below.
Issue DOM-309, Second Request for Information, at the end of the DOM-307 request period for any missing information or action addressed on the DOM-307. Do not request any new or additional information on the 309; a new 307/309 is required for information or action not addressed in a previous 307/309.	**Issue DOM-307**, Request for Information, when needed information is not available from electronic data sources or attempts to contact the applicant by telephone are unsuccessful. List specific information needed to determine eligibility.
Request for additional time – for both ABD and MAGI, if the applicant contacts the agency to request additional time, the applicant will have the remainder of the 45-day processing period to submit requested information or take necessary action. (NOTE: for ABD disability applications subject to the 90-day processing period, a denial cannot be issued prior to securing the DDS decision, which may allow additional time for the ABD applicant to provide other needed information.) Explain to the applicant the latest date that can be allowed to submit information or take necessary action to avoid a denial for failure to provide requested information. Assist the applicant as needed or requested to secure needed information.	
Failure to provide requested information – if the applicant has not fully complied by the due date on the 307 (for MAGI) or on the 309 (for ABD) and has not requested additional time, the application will be denied due to the failure to provide needed information or take required action. (NOTE: for ABD disability applications subject to the 90-day processing period, a denial cannot be issued prior to securing the DDS decision, which may allow additional time for the ABD applicant to provide other needed information.) Document the denial notice to inform the applicant of the missing verification or action that is the basis for the denial.	

101.08.03A ELECTRONIC DATA SOURCES UTILIZED BY DOM

For MAGI-related applications, all available electronic data sources are utilized and evaluated to attempt an eligibility determination. If information provided on the application is not consistent with electronic data source verification, the head of the household for the MAGI application must be contacted by telephone for a reasonable explanation of any relevant discrepant information. If a

reasonable explanation is not provided, paper verification is requested using the DOM-307, Request for Information, as outlined above.

ABD applications utilize the same electronic data sources shown below except MDHS Data History. ABD resource tested applications also use the Fraud and Abuse Module (FAM) for resources. See 303.05 for FAM procedures.

Electronic data sources utilized by the agency include the following:

- Social Security Administration – verifies non-financial factors of eligibility such as SSN verification, U.S. citizenship verification, age verification, disability onset date, if appropriate, and financial verification of benefits paid through SSA.
- Department of Homeland Security – verifies immigration status of immigrants in possession of immigration or naturalization papers that can be used to match with Homeland Security.
- Department of Employment Security – verifies wages reported to the agency as the State Wage Information Collection or SWICA agency. Also verifies Unemployment Compensation benefits paid.
- TALX or FDSH – commercial database that verifies wages reported by employers that utilize this service.
- EVVE or Electronic Verification of Vital Events – verifies birth and death records for births and deaths in all states that utilize this service.
- Office of Child Support Enforcement (through the Department of Human Services) – verifies compliance with child support requirements for adults subject to this provision as a post-eligibility requirement.
- PERS or Public Employees Retirement System (in MS) – verifies benefits paid by PERS.
- MDHS Data History-provides income, household composition, and eligibility data that the Mississippi Department of Human Services has on file from their SNAP and TANF programs. Income verified by SNAP (but not TANF) can be used to verify income for MAGI.

101.08.03B ELECTRONIC DATA SOURCES UTILIZED BY THE FFM

The FFM utilizes electronic data sources such as the Social Security Administration, TALX, and the Department of Homeland Security to determine eligibility for participation in a qualified health plan or potential eligibility for MAGI-related Medicaid or CHIP. Verified information is passed to DOM through the Account Transfer (AT) record along with attested information from the application filed with the FFM. AT records are then matched or are available for matching with DOM utilized data sources.

101.08.04 SUPERVISORY REVIEW

Each ABD and MAGI-related eligibility determination must be authorized 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 the system. The exceptions to supervisory review include childless adult denials, the addition of a deemed infant to a case, family planning and pregnant women approvals. Secondary supervisory review of a case processed by designated experienced staff members may also be waived at agency discretion during times of severe staff shortages, unwinding from public health emergency, or statewide effort to achieve timeliness.

101.08.05 APPLICATION ACTIONS

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

- **Approval** – When all the eligibility factors are met, the application is approved, and the applicant is notified in writing or electronically of the approval.
- **Denial** – When one or more eligibility factors are not met, the application is denied, and the applicant is notified in writing or electronically of the denial. Adverse action does not apply. **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.

101.08.06 COMPLIANCE AFTER DENIAL

If a MAGI or ABD applicant provides all needed information to complete the application within 90 days following denial, use the denied application form to establish eligibility using the original application date. Reinstate the application in the system using the original application date.

For example, the application is denied on September 12th. If all needed information is provided on or before December 11th, the application can be reinstated.

If, as a result of new information provided, additional information is needed to complete the application, attempt to handle these issues by telephone contact, if possible. If not possible, issue a DOM-307 (and DOM-309 for ABD, if needed) specifying what is needed to comply. Allow 15 days for the information to be returned.

- If requested information is not provided, no further contact with the individual is required unless the information needed is provided during the remainder of the compliance period. Close the reinstatement contact, delete the time period and document the case narrative.
- If all information is provided, take action to approve the application if eligible or deny the application for the appropriate reason if ineligible.

101.09 COMBINATION MAGI AND ABD APPLICATIONS

Although MAGI and ABD are separate programs, there are common elements that allow an individual to apply in one program but be determined eligible in the other using available information.

The MAGI application asks specific questions at the individual level regarding possible ABD eligibility. These questions ask if the applying household member:

- is disabled, or
- has a physical, mental or emotional condition that limits common activities, or

- lives in a medical facility or nursing home.

An affirmative response to any of these questions requires further development as quickly as possible during the MAGI application process to follow up on possible ABD eligibility if it is unlikely that the individual will qualify for MAGI based on application information. For example, an applying household member is over the age of 18 and is not a parent or caretaker of a minor child in the home, or the parent/caretaker has income over the limit for adult coverage, or a disabled child's family income is over the Medicaid and CHIP limit. In all these situations, if a disability is alleged for an applying MAGI household member, that individual must be allowed the opportunity to apply for ABD in an expeditious manner.

MAGI Application Filed with DOM Indicates Possible ABD Eligibility

To fulfill the requirement for a MAGI applicant to apply for ABD when a MAGI application indicates possible ABD eligibility, do the following:

- Issue the ABD application form (DOM-300) via DOM-307 requesting only the information that is not available as part of the MAGI application process. The types of verification needed to establish ABD eligibility may be:
    - Requesting disability information for a DDS decision if disability cannot be established using electronic verification from SSA on the SVES.
    - Verification of any income not counted for MAGI purposes, such as VA benefits, that will not be verified during the MAGI application process.
    - Verification of resources for the individual, couple, or parent(s) of a disabled child, which are not considered for MAGI eligibility.

- A signed ABD application form is required to formalize receipt of an ABD application. If a signed (complete or incomplete) ABD application

form is not received, document the MAGI case that there is no further action required regarding ABD follow-up.

- If a signed ABD application form is received but missing required information, obtain the information by using telephone contact when possible or the issuance of DOM-307/309 to obtain missing information.

- Telephone contact with the ABD applicant or representative may be used in this situation to describe the ABD application process and to inform the ABD applicant of any other requirements unique to ABD. These include ownership of resources, requirements to consent to the AVS (Asset Verification System) requirement described on the application form. For any application for long term care or institutional ABD categories of eligibility, a telephone interview is required to explain any applicable long term care provisions such as estate recovery, spousal impoverishment, transfer of assets, Medicaid Income and the Income Trust provision that are not applicable to MAGI eligibility.

If the ABD applicant(s) follow through with the remaining ABD application requirements, such as providing requested information or taking required actions, the ABD application can be processed and approved regardless of the action taken on the MAGI application. If the MAGI and ABD applications are approved, the case becomes a combination ABD/MAGI case in MEDS and is handled accordingly.

MAGI Application Filed with the FFM Indicates Possible ABD Eligibility

For MAGI applications filed with the FFM and referred to DOM as an Account Transfer, the system recognizes any affirmative responses to the questions that indicate a request to apply for ABD Medicaid and issues DOM-304, Non-MAGI Application Letter (located in the Appendix page by the same name). This letter informs the applying household member that additional information will be needed if the applying household member wants to pursue applying for Medicaid based on disability, i.e., resource information and disability information unless

the individual has already been determined disabled by SSA. The letter instructs the individual to sign, date and return the letter to DOM by mail, in person, by fax or email if he/she wants to continue with an application for ABD Medicaid or, if needed, the individual can contact the agency by phone to continue the process.

If an individual signs and returns the "non-MAGI letter" to the agency via any means acceptable for filing an application, an ABD application must be issued to the individual and the steps described above in "MAGI Application Filed with DOM Indicates Possible ABD Eligibility" must be followed for processing the ABD application.

If a signed non-MAGI letter is not returned to the agency, no further action is required.

101.10 ELIGIBILITY DATES

The following discussion addresses Medicaid and CHIP beginning dates of eligibility, ending dates of eligibility, and retroactive Medicaid eligibility.

101.10.01 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.
- The first day of the month following the month of approval for QMB-only (Qualified Medicare Beneficiary) eligibility. There is no retroactive Medicaid possible for a QMB-only.
- The Hospital Presumptive Eligibility (HPE) beginning date of eligibility is the date the HPE application is approved by authorized hospital staff.

- Presumptive eligibility for pregnant women (PEP) beginning date of eligibility is the date the PEP application is approved by provider/entity staff.

101.10.02 BEGINNING DATES OF CHIP ELIGIBILITY

The benefit start date for CHIP is the first day of the month following the month of application, provided all eligibility factors are met. There is no retroactive eligibility for CHIP-eligible children, other than the newborn exception described below.

Newborn exception: The start date for a CHIP-eligible newborn may be retroactive to the date of birth if the application is filed within 31 days of birth. The 31-day count for the application to be filed begins the day following the infant's date of birth.

101.10.03 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.
- Hospital Presumptive Eligibility (HPE) termination dates are either the last day of the month of the HPE period or the day of the month that the full application for Medicaid is denied.
- Presumptive Eligibility for Pregnant women (PEP) termination dates are either the last day of the month of the PEP period or the day of the month that the full application for Medicaid is denied.

101.10.04 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. A child who is eligible only in a retroactive month will receive Medicaid for 12-continuous months beginning with the month eligibility starts.

- 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.
- Hospital Presumptive Eligibility (HPE) has no retroactive coverage. If a full application for Medicaid is filed and approved, retroactive coverage is available for up to 3 months prior to the month the full Medicaid application is filed. In addition, any partial month of eligibility granted under HPE begin date rules will be changed to full month eligibility.
- Presumptive eligibility for pregnant women (PEP) has no retroactive coverage. If a full application for Medicaid is filed and approved, retroactive coverage is available for up to 3 months prior to the month the full Medicaid application is filed. In addition, any partial month of

eligibility granted under PEP begin date rules will be changed to full month eligibility.

101.10.04A RETROACTIVE MEDICAID FOR ABD APPLICATIONS

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.

101.10.04B RETROACTIVE MEDICAID FOR MAGI-RELATED APPLICATIONS

Income determined for current eligibility is used for the retroactive period for MAGI-related cases unless there was a change that must be considered for eligibility in the retroactive period. 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, such as electronic data source verification is inconsistent with the applicant's statements or declared information.

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

101.10.05 RETROACTIVE MEDICAID FOR 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.

101.10.06 RETROACTIVE MEDICAID FOR SSI ELIGIBLES AND FILLING IN GAPS

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. However, if an application for retroactive Medicaid was filed and either approved or denied within 90-days of a request to fill in missing month(s) of SSI eligibility, reinstate the prior application using current verification needed to determine eligibility for any missing month(s). The reinstatement is only for the purpose of using the previous application. Eligibility is approved only for the missing month(s) provided the SSI individual is eligible in the missing month(s).

101.11 NOTIFICATION

The recipient and, when applicable, the medical facility must be notified in writing or electronically of the action taken on an application or an active case when eligibility or benefit level is affected by a change either at the time of a full review or as a result of a reported change prompting a special review. Notices are generated by the system 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 in the system 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 Long Term Care Facility and Medicaid Regional Office, is used.

101.11.01 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. However, federal regulations also require that for continuation of benefits to apply when requesting a hearing, the 10-day advance notice period includes 5-days mailing time. To simplify this requirement, the adverse action deadline is set for the 15th of each month except in February, which is the 13th of the month, to ensure a minimum of 5-days mailing time.

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.

101.11.02 EXCEPTIONS TO ADVANCE NOTICE

Unless noted, the following actions require notification to the recipient; however, 15-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 the system if the termination reason is death.

Some acceptable sources to verify the death date are:

- SVES, SDX, or EVVE
- Report from recipient's representative or the MAGI Head of Household.
- Viewing the death certificate.
- Contact with the funeral home or the attending physician.
- DOM-317 from the nursing home or contact with the hospital or nursing home where the patient died.
- Obituary.

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.

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 a MAGI-related 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.

101.12 PROCESSING DOM EMPLOYEES/FAMILY MEMBERS CASES

Cases for DOM Office of Eligibility 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, ex-spouse, children, stepchildren, ex-stepchildren, children's spouses and the following relations to

the employee *or* employee's spouse or ex-spouse: mother, father, stepparent, 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 Office of Eligibility employees, household members and their immediate family members must be marked as DOM employees in the system to limit system access to all members of 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.

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

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

Application or renewal form and documents must be sent electronically to appointed Central Office staff. Central Office staff only will access the case in MEDS to register, upload, and scan any documents. The employee's name and relationship to the client must be reported by the RO.

Conflict of interest cases or relative cases that are not within the specified degree of relationship listed above should be handled by Regional Office supervisory staff.

Cases for DOM Employees who do not work for the Office of Eligibility should be handled by the Regional Office.

Prior to authorizing eligibility, the assigned Central Office staff member 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.

The process described above includes all activity on affected cases at the time of application and review, including special reviews of all such cases.

Regional Office staff should inform the Central Office when employees who have an employee or family member case leave the agency. Central Office staff will remove the employee indicator and transfer the case back to the Regional Office.

101.13 SERVICE DELIVERY SYSTEMS

The Division of Medicaid operates under two different payment models for services which are fee for service and coordinated care. Once an applicant is approved for Medicaid or CHIP, the individual is enrolled in one of these payment models based on their category of eligibility, age and whether enrollment is mandatory or optional for their category.

1. Fee for Service (FFS) – the recipient chooses his/her own provider of service that accepts Medicaid, and the provider is reimbursed by DOM. Fee for Service recipients are entitled to the full array of Mississippi Medicaid State Plan covered services.
2. Coordinated Care – this is a type of managed care whereby certain recipients are either required to enroll or may voluntarily enroll in a Coordinated Care Organization (CCO) and have their medical care managed by the CCO selected. CCO's connect enrollees to a medical home and provide care management and disease management programs in an effort to provide cost-effective medical services. CCO's are paid a capitation rate per enrollee and in turn, the CCO pays the medical claims to the Medicaid provider. CCO's are required to cover all Mississippi Medicaid State Plan covered services unless the contract with the CCO's states otherwise; however, CCO's can also offer additional services not covered in the Mississippi State Plan, such as additional physician visits or additional pharmacy benefits.

CHIP enrollees are required to select a CCO. Benefits covered are those required by the DOM CHIP Plan.

For additional information on MSCAN and the mandatory and optional categories of eligibility that can or must enroll in a CCO, refer to the DOM website.

101.14 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 (MAGI-related or ABD).

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 from Medicaid to CHIP unless the Head of Household voluntarily requests early termination, or the child was approved in error in the current program.

101.14.01 EARLY TERMINATION REASONS FOR CHILDREN

The following reasons may shorten the 12-month certification for a child in MAGI-related 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 MAGI-related or ABD program, his eligibility must be terminated. Refer to "Ex parte Reviews" later in this chapter for further discussion on assessing eligibility in another program.

    - When a child in the Katie Beckett Program will age out of this program, continued eligibility must be assessed in another program.
    - When a MAGI-related child turning age 19 is pregnant, the child will remain in her current coverage through her post-partum period if the pregnancy information is verified and coded in the system.

- At review, an assessment of eligibility in other age-related MAGI categories is automated in the system. For example, an uninsured child turning age 6 in COE-072 during the new 12-month eligibility period will move to either COE-073, 074 or CHIP the month following his/her 6th birthday.

- 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 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 this additional reason:

- The CHIP-eligible child becomes eligible in the 88-program due to pregnancy The child will remain in COE 88 and will be reviewed at the end of the post-partum period.
- The CHIP-eligible child becomes eligible for Medicaid.

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.

101.14.02 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.

Specialists must 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.

If the mother is not eligible for Medicaid at the time her child is born, she may apply for Medicaid for herself and her newborn. The application must be filed timely for Medicaid to be retroactive to the birth of the child, i.e., an application must be filed by the end of the 3rd month following the birth month of the child. If all eligibility factors are met, the mother and newborn may be eligible for up to 3 months prior to the month the Medicaid application is filed. If the mother and newborn are determined eligible, the mother will be covered throughout her post-partum period and the newborn will be eligible for 12 continuous months.

101.14.03 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 any COE program are

provided coverage from their first eligible month through the post-partum months regardless of any subsequent changes in income, household composition, etc. This includes women whose eligibility originated in a non-pregnancy related coverage group, such as QMB or Family Planning, who are determined eligible for any COE and transition to any COE for coverage of pregnancy related services for the duration of her pregnancy and post-partum months. In such instances, eligibility must be reviewed for the impact of any changes in circumstances after transitioning back to her original coverage group.

101.15 THE REDETERMINATION OR RENEWAL 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 that are subject to change. 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 addresses the redetermination process.

101.15.01 REGULAR REDETERMINATIONS OR RENEWALS – MAGI & ABD

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 circumstances are reviewed and each eligibility factor that is subject to change, such as income and/or resources, is re-evaluated. Recipients are not asked to provide information that is not relevant to ongoing eligibility or that already been provided and is not subject to change.

101.15.01A FREQUENCY OF REVIEWS

A full review must be conducted for all eligible household members (MAGI and ABD) 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, a redetermination contact will be set on everyone to *attempt* to align redetermination dates for the following year and assure one annual review for case members:

- Adults in the case can have their 12-month review period shortened by a change in circumstances that affects adult(s) in the case. The exception is a pregnant adult who is eligible in any COE.
- Children that are not due for review require special handling to ensure protection of their 12-months of continuous eligibility, as described in 101.16.01B and 101.16.01C below.

101.15.01B 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 , the action must be effective at the end of the current 12-month review period. To process the termination or change in the system, 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, action must be taken prior to the end of May.

101.15.01C PROCESSING CHILDREN NOT CURRENTLY DUE FOR REVIEW

Each 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 Medicaid to CHIP unless the parent or other authorized person voluntarily requests early closure in the current program, or the original determination was in error.

When reviewing a case with different review due dates and the current review is for the person with the earliest review due date, it is appropriate to set a redetermination contact for all case members; however, the current review and any requests for information must be focused on the case member(s) due for review. Do not request any information on any *children* with a future review due date. If updated information is provided during the review which results in eligibility for all case members, eligibility can be extended for all members, including children with a future review due date.

If updated information results in ineligibility for any child with a review due date in the future, it is not possible to take action to terminate eligibility prior to the end of the 12-month continuous period. Future termination dates for children not currently due for review are not permitted. Instead, the child or children must be fully reviewed at the end of the 12-month protected period of eligibility. This includes a deemed eligible newborn who is eligible for the first full year of life. Retract eligibility and cancel the redetermination contact for any children affected by a finding of ineligibility.

When a program change is involved for a child with a future review date, the change from Medicaid to CHIP cannot be made until the end of the child's current eligibility period unless the parent or other authorized person consents to early termination in the current program. The change must be reported to the parent or other authorized person by DOM, and consent for the program change must be documented in the case narrative.

Changes from CHIP to Medicaid must be acted on.

Retract eligibility and cancel the redetermination contact for any children affected by a change from Medicaid to CHIP that has not been approved.

101.15.01D PROCESSING AN APPLICATION AND A REVIEW

As previously indicated, when an application is filed to add a new child or adult (MAGI or ABD) to an active case, a review is completed for existing case members at the same time the application for the new member is processed. However, the same policy requirements apply for an application and a review as exists for processing an active case with children not currently due for review:

- Do not request any information on any children with a future review due date.
- If updated information is provided for the applicant that results in eligibility for all case members, eligibility can be extended for existing case members, including children with a future review due date.

- If updated eligibility results in ineligibility for any child with a future review due date, the child or children must be fully reviewed at the end of their 12-month protected period.
- A change from Medicaid to CHIP for a child with a future review date is prohibited unless the parent or other authorized person requests early termination in the current program.
- If a finding of ineligibility or a program change results for existing children in the case who are not due for review, retract eligibility and cancel the redetermination contact for the child(ren) with a future review due date.

101.15.02 ASSIGNMENT OF REVIEW DUE DATES

A regular review must be completed on each recipient at intervals not to exceed 12 months. The system automatically sets a 12-month review at application and redetermination as follows:

APPLICATIONS	REVIEWS
MAGI applications – a Medicaid application month starts the 12-month count. (Application month + 11 months = review due date.) For CHIP, the benefit month starts the 12-month count (Month after month of application + 11 months = review due date.)	MAGI and ABD review due dates are determined using the time period begin month to start the 12-month count. (Begin month of time period + 11 months = review due date.) Pregnant Woman's due date is set to the 12th month of post-partum. 12 months after the end of the pregnancy.
ABD applications – the month the supervisor authorizes eligibility starts the 12-month count. (Supervisor authorization month + 11 = review due date.)	

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. No individual's review due may be adjusted to exceed 12 months.

Setting Correct Time Spans to Ensure a Child's 12-Months Continuous Eligibility

Because children (MAGI or ABD) can be added to a case at different times (birth of a child or addition of a child to a case), not everyone within a case may have the same review due date. As stated previously, all children under age 19 (MAGI and ABD) are entitled to 12-months of continuous eligibility.

The system sets the review due date based on the beginning month of the time period entered. When completing MAGI and/or ABD redeterminations, the time period must be set as follows:

Overdue for Review	Set the time span for the month following the month the pre-populated renewal form is received. Children who are approved will have a new review due date 12 months from the time period begin date. Ineligible children must have a full review at the end of their 12-month protected period.
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.

101.15.03 ADMINISTRATIVE EX PARTE RENEWALS

An administrative ex parte renewal allows eligibility to be renewed based on reliable information contained in the case record and other more current information available to the regional office, such as current data secured from electronic data sources.

- An ex parte review must be attempted on every client due for review. An ex parte review is ***required*** annually for SSI-only cases in Long Term Care in COE-005. SSI-only reviews must be completed, or, at a minimum, a redetermination contact must be registered, prior to the scheduled mailing of a pre-populated renewal form for the SSI-only case to prevent a pre-populated renewal form from being issued. For SSI-only reviews, the action needed is to verify the individual remains in the facility, check the SDX for any changes and attempt verification of any resources, such as a patient account or other type(s) of resources available to the SSI recipient.
- An ex parte review is processed without contacting or requiring information from the household. If there is no known change in household circumstances and if all reported income types can be verified through available electronic data sources, use current income verification from these sources to renew eligibility.
- When electronic data sources indicate a different employer for a household member than the previous year, an ex parte review is still possible if the income results in eligibility for a beneficiary. A change in employer is not a factor in determining eligibility for an ex parte review.
- When a client is approved with zero income at application or full review, DOM can complete future reviews ex parte if no data is returned showing countable income at renewal. The client can be renewed ex parte up to 3 times before a full review is needed to get a new attestation of zero income.
- Individuals with retirement benefits that are verified at initial application and remain the same for each payment period (month/quarter, etc.) can be renewed ex parte with notation in case narrative that the retirement/pension benefit is stable income and does not change. Individuals who draw retirement benefits that include an annual cost of living adjustment, such as state retirees from other states, are not candidates for ex parte review since their benefit will gradually increase each year.
- FAM should be requested as part of the ex parte process for all resource based COEs. Give FAM 5 business days to return. If FAM does not return on a previously verified resource, the worker can use

the amount from the last decision when completing the ex parte review. Document in case narrative that FAM did not return, and DOM is assuming no change in assets. Any FAM data returned following completion of the renewal must be documented and addressed if needed.

- If all beneficiaries due for a review can be *approved in the same or better program* using current information verified through electronic data sources, the recipient is notified of the approval. A pre-populated renewal form is not generated for administrative ex parte renewals.
- If an ex parte review does not result in an *approval in the same or better program,* a pre-populated form must be issued to allow the recipient to provide current information. It is possible to move a beneficiary from one Medicaid program to another Medicaid program that provides the same or better coverage based on an administrative ex parte review; however, a child cannot go from Medicaid to CHIP or CHIP to Medicaid.
- If some household members due for a review can be renewed ex parte, but other household members due for a review cannot, a prepopulated form must be issued. The household members eligible for an ex parte review must be renewed ex parte when the review form is returned. If the form is not returned, the household members eligible for ex parte review still must be renewed ex parte.
- If a recipient reports a change in response to an administrative ex parte renewal approval, document all changes on the "Administrative Review Contact Documentation" form located in the Appendix page by the same name. Attempt verification of a reported change through electronic data sources before requesting information directly from the recipient.
- Handle reported changes as a redetermination contact in the system. The appropriate approval or denial notice will be issued based on the outcome of the reported change. Children may not be terminated or switched from Medicaid to CHIP due to a reported change after an ex parte review is completed.
- Automated generation of pre-populated review forms take place on a schedule that is published annually and is based on the review due

month. Ex parte renewals must be registered as a redetermination contact with a time period pending *before* the scheduled generation of a pre-populated form. Medicare cost-sharing cases marked "Yes" under "reduced Coverage Adm Review Criteria Met" on the RJ831 and RJ831w will not have an automated prepopulated review form mailed by MEDS. These cases will require a manual prepopulated form to be mailed if an administrative ex parte review cannot be completed.

Every regional office must have a process in place to ensure ex parte administrative renewals are attempted as required prior to the scheduled mailing date for the system to issue a pre-populated review form.

101.15.04 PRE-POPULATED RENEWALS

If a renewal of eligibility cannot be accomplished by an administrative review, a pre-populated review form is issued to the recipient displaying the information that is available to the agency. The renewal form is an initial request for information. Renewal due dates are included on the form which provides the recipient with time to respond and provide any necessary information specified on the form that is needed to renew eligibility. Renewal includes returning the signed renewal form. Renewal due dates are as follows:

- MAGI-related and ABD renewals have 30-days from the date the renewal form is issued.

The signed form and any paper verifications may be returned to the Division of Medicaid through any of the methods permitted for submission of applications.

MAGI pre-populated renewals are issued with known household composition and demographic data, current income information, tax and dependent status of each known household member and information on any health insurance coverage for household members. There is space on the form for the head of the household to make any needed changes to information reported on the form.

ABD pre-populated renewals are issued with known demographic and income information for each eligible individual or couple. There is space on the form

for the individual or couple to make any needed changes to information reported on the form.

- Pre-populated renewal forms (MAGI and ABD) are issued by the system two months in advance of the review. For example, May renewals are mailed out or available on Common Web Portal for beneficiaries with accounts (with electronic notice issued) to recipients in March and are due for completion/return to the Regional Office by April 15th. Reviews must be completed for adverse action by May 15th or the end of May, as appropriate.
- The case must have no open contacts or pending time periods by the published deadline in order for the system to generate a pre-populated renewal form. Any cases that are not in the appropriate status as of the date of mailing will be by-passed by the system making it necessary for the specialist to issue a pre-populated renewal form manually. If a renewal form is issued manually, the specialist must pre-populate the form will all known information required by the renewal form.
- If a returned form is incomplete, meaning there is missing information or verification needed, attempt a telephone contact with the head of household to explain what is needed. For incomplete renewals, use DOM-307 to request any missing verification(s).
- If a returned form results in the reporting of new or additional information that was not previously reported, and verification of the information is not possible for the regional office to obtain:
    - For MAGI cases, attempt a telephone contact to request the needed verification. If contact is unsuccessful, issue DOM-307 requesting the new or additional needed information in writing.
    - For ABD cases, use DOM-307 and, if needed, DOM-309 to request any new or additional information.
- If a renewal form (MAGI or ABD) is not returned by the due date, attempt telephone contact with the recipient as a reminder that the form is due for completion and return to the regional office via mail, in-person or electronically.
- When the ABD or MAGI recipient or head of household fails to provide all needed information, action cannot be taken to terminate eligibility due to failure to provide information without first attempting a telephone contact

to inform the individual of the information needed and when it must be provided to prevent termination. All efforts to contact the individual must be documented in the case record.

- When a renewal form or other requested information is not returned, the worker must attempt to use available electronic data sources to complete a renewal. Any beneficiaries who could be renewed ex parte must be renewed ex parte. Any clients who would change from Medicaid to CHIP, CHIP to Medicaid, or to a lower coverage group must be changed to the new coverage.
- Monthly and Weekly Redetermination Due Listings for both ABD and MAGI cases are available in the system to track and monitor cases due for review. Cases that are overdue for review are also part of these reports.
- If needed information is provided after the applicable due date for renewal, refer to 101.16.12 "Requested Information Provided After Closure."

101.15.05 RETURNED MAIL FROM REDETERMINATIONS

When an administrative approval notice or a pre-populated review form is returned by the post office, handle as follows:

- If mail is returned with a forwarding address, attempt a telephone contact to confirm the address. If a telephone contact is not successful or possible, update the address and re-route the mail. Document all contact attempts.
- If mail is returned without a forwarding address, attempt telephone contact(s) with the household to determine the current address. If all reasonable attempts to contact the household are exhausted and the current address cannot be obtained, terminate eligibility due to "unable to locate."
- If the current address is subsequently obtained for an administrative review approval and it is determined the basis of eligibility in the administrative review was otherwise correct, i.e., no household or income changes, recipients may be reinstated with no loss of benefits if within 90 days of the date of closure. If new income or household information is reported, use the "Administrative Review Contact Documentation" form to collect information. If verification is needed, attempt to obtain it through

available electronic data sources before requesting information from the recipient(s). Use a redetermination contact to conclude the review in the system.

- If the current address is subsequently obtained for a returned pre-populated form within 90 days of the date of closure, issue the form to the current address and allow 30 days for the form to be returned.

101.15.06 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.

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.

101.15.07 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 or CHIP 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.

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

The adverse action deadline is the 15th of the month in order to allow 10-days advance notice plus 5 days mailing time. 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.

If Medicaid or CHIP termination action is authorized by the 15th 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 is the 13th.

NOTE: Non pregnant 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.

101.15.08 EX PARTE 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 "ex parte 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 Ex Parte Determination

For an ex parte 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 ex parte 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 ex parte determination.

Basis for the Ex Parte 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. It also includes information received through electronic matches with other state/federal agencies such as a disability onset date or prior receipt of benefits based on disability.

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.

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 a MAGI 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 ex parte 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 the information needed to assess eligibility in the new program within 90-days of termination, the case should be handled in accordance with "Requested Information Provided After Closure," described in 101.15.12.

> 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 ex parte 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 ex parte 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 10th, the child is determined eligible in the Katie Beckett Program. Her CHIP eligibility is terminated effective August 31st and ABD Medicaid eligibility is authorized effective September 1st in the system.

101.15.09 SSI REVIEWS REQUIRED FOR SSI TERMINATIONS

The SSI review process is a type of ex parte review. When individuals are terminated from SSI due to income and/or resources, they are systematically issued an SSI Termination Notice and an SSI Review Form, DOM-300B, 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. A signed form is required. The form may be complete or incomplete. If incomplete, the specialist will take the necessary steps to obtain needed information.

NOTE: The SSI Termination Notice advises the individual to complete and return the form to the regional office with 10-days from receipt of the notice; however, allow the form to be returned prior to the date of the SSI closure.
SSI/Medicaid closures are effective for the end of current month only if the SSI transaction to close SSI/Medicaid is received by the 10th day of the month; otherwise, the closure is effective at the end of the following month. If the DOM-300B is not received timely, the individual can apply at any time using the full ABD application form.

All necessary factors of eligibility must be verified, such as disability, residency, 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.

101.15.10 RECEIPT OF REGULAR REVIEW FORMS

MAGI-related and ABD regular reviews may be submitted to a regional office by any of the means allowed for filing an application. Receipt of a redetermination or review form includes pre-populated forms that were issued by the system or manually, SSI review forms, and ABD review forms issued systematically or manually. These forms may be received in any of the following ways:

By mail in any regional office or in the central office.	If received in the incorrect RO, forward to the correct RO in the same manner as an application.
By fax.	An original signature is not required.
In-person in any regional office, out-stationed site or other location where eligibility staff are on official duty.	If assistance is requested in completing the renewal form, assistance must be provided on the day the individual comes into the office or other location.
By telephone. Assistance completing the review form must be offered if needed.	The Telephonic signature must be recorded
Electronically via email	Beneficiaries can upload and submit renewal form via email to the RO.
On-line	Beneficiaries can utilize the common web portal (CWP) self-service component to complete renewal form and upload needed documents..

101.15.11 DISPOSITION OF A REGULAR REVIEW – ABD AND MAGI

ABD and MAGI redeterminations are completed administratively, if possible, or by use of a pre-populated review form that is issued either systematically or manually, as discussed above. When the form is returned and all information subject to change has been evaluated and a decision is reached regarding continuing eligibility, the following actions will be authorized:

101.15.11A APPROVAL OF A REGULAR REVIEW

When the ABD recipient/representative or MAGI head of household has complied with all redetermination requirements and provides required verifications, the specialist will review the eligibility criteria; ensure appropriate documentation is filed systematically in the case documents structure and input the data into the system for an eligibility decision. All redeterminations are submitted for supervisory review and authorization. Secondary supervisory review of a case processed by designated experienced staff members may also be waived at agency discretion during times of severe staff shortages, unwinding from public health emergency, or statewide effort to achieve timeliness. When eligibility will continue at the same level, a new review due date is established, and an approval notice issued to the recipient or head of household when benefits are authorized.

101.15.11B REDUCTION OR 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 recipient or 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.

For MAGI-related cases, adverse action is required in the following situations:

- Termination of benefits for one or all members of the household
- Change from Medicaid to CHIP
- Change from CHIP to Medicaid

- Conversion to a reduced services coverage group

For ABD cases, adverse action is required in all the following situations:

- Termination of benefits.
- Conversion to a reduced services coverage group.
- Termination of a nursing facility per diem payment.

The system 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 ABD recipient or MAGI head of household subsequently complies with all redetermination requirements or provides information which changes the negative action, eligibility must be reinstated. 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.

ABD 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 recipient 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.

MAGI Example: The head of household failed to comply with redetermination requirements for a May redetermination. The case was closed on May 15th effective May 31st. On May 29th partial verification is provided; however, all information needed to process the case is not provided. A reinstatement contact is registered for May 29th. A 307 is issued for the information and 30-day processing is applicable.

101.15.12 REQUESTED INFORMATION PROVIDED AFTER CLOSURE

When an ABD or MAGI case is closed due to failure to provide information, a reapplication is not required if the following are met:

- The recipient or head of household subsequently provides all information necessary to complete the redetermination; **and**
- The case has been closed for 90-days or less at the time the information is provided.

  Example: The recipient did not provide income verification needed for the May redetermination. The closure is authorized on May 10th effective May 31st. If the information is furnished by August 31st, eligibility can be determined using the reinstatement process. After August 31st, a reapplication must be filed.

NOTE: If a MAGI-related child was not due for review when action was taken to terminate other household members who were due for review, the 90-day provision described above does not apply since any child(ren) not due for review could not have been closed with a future date. Children undergo a full review at the time end of their 12-month protected period.

The specialist is responsible for taking action within 48 hours of receipt of the information to register the reinstatement in the system. The case will be processed based on the most recent application and/or renewal form. There is no requirement to obtain an updated signature on the application form. Refer to the Reinstatement policy for a complete discussion of the process required to reinstate eligibility.

101.16 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: A COE-075 adult recipient reports three months after her regular redetermination that she has a part-time job. The children in the case have income from Social Security which was last verified at the regular review. The Social Security 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. Special reviews are handled differently, depending on the impact the change may have on eligibility and is discussed below.

101.16.01 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, by mail, through the Common Web Portal, or by fax to the agency. 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.

101.16.02 CHANGE REPORTING REQUIREMENTS - ABD

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.
- Changes in health insurance premiums for LTC recipients.

101.16.03 CHANGE REPORTING REQUIREMENTS – MAGI PROGRAMS

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

All MAGI 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.

COE-075 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.

COE-075 Adults on Extended Medicaid

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

101.16.04 PROCEDURAL CHANGES – ABD and MAGI

Procedural changes 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 the system, name, address, SSN, race and gender can be changed or corrected on a processed time span.

101.16.05 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 Medicaid or CHIP child is not a reportable change because of the continuous eligibility provision for children. The impact of an increase in parental income will be considered at the next review. However, if the parent reports an eligible 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 with a 30 day deadline to provide written notice of the required information and due date. Action is taken on changes as follows:

- Reported changes with the likelihood that eligibility will be adversely affected require development, which may mean a request for additional information is needed. Failure by the MAGI head of household or ABD recipient or representative to respond to needed information will result in termination of eligibility for any adult(s) affected by the change. Changes can include, but are not limited to, the report of a marriage with additional household income to consider, a new job for a household member or any type of change indicating an additional source of income.

- A negative change reported during a review period that affects eligibility for adult(s) is handled at the time of the reported change; however, it is not permissible to take punitive action on the children in a case due to action being taken for the adult's eligibility. This includes not setting future termination dates for the children at the end of their 12-months of continuous eligibility. Children must be reviewed so their eligibility is assessed at each annual review. For example, an adult reports marriage and is terminated during the review period because spousal wages were requested but not verified. The non pregnant adult's eligibility is terminated. A future closure would not be set for the children. The child's eligibility must be reviewed at the next annual review. If information needed at the time of the annual review is not provided, the children's eligibility would be terminated as a result of the annual review.
- If there is a case change, such as the addition of a parent, that results in information that must be requested to confirm the parent's eligibility, do not require updated information for a child's eligibility. Handle the child's eligibility at the next annual review.
- Reported changes that will not likely affect eligibility for the household should be developed but if a request for additional information yields no response, it is not permissible to terminate eligibility for a failure to respond to the request. Instead, follow up at the next review. These types of changes may include a change of address for the household when a move out of state is not indicated, loss of an income source to the household, the death of a child's parent or other types of changes that would not result in a loss of eligibility.
- Reported changes or actions taken during a review period can affect one or more household members but not the entire household. The option to perform an early review can be offered but cannot be required for a child's eligibility.
- A change during the review period that results in updated information on all household members can result in eligibility being extended for the household. For example, during the review period a parent applies and is added to the case. All household income is updated and verified. It is permissible to extend eligibility for a new 12-month review period for the children under these circumstances.

- Reported changes that would change a child from CHIP to Medicaid must be acted on. Children cannot be switched from Medicaid to CHIP during the child's 12 months of continuous eligibility

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.
- What action was taken regarding the verified information.

101.17 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 MAGI recipients via a Reinstatement contact in the system.

101.17.01 INFORMATION PROVIDED PRIOR TO EFFECTIVE DATE OF CLOSURE

If the recipient provides information that changes the adverse action decision or fully complies with unmet requirements prior to the effective date of the closure, benefits must be reinstated to ensure no loss of benefits, if the recipient remains eligible. If the information provided does not change the adverse action decision, no further action is required.

If advance notice of Medicaid and/or CHIP benefit reduction or termination was not issued as required, benefits must be reinstated back to the date of closure

at the time the error is discovered, regardless of whether the client is currently eligible.

After benefits are reinstated, advance notice would then be issued to close the case to meet the advance notice requirements. Close the case at the end of the advance notice period.

101.17.02 90-DAY REINSTATEMENT PERIOD FOR MAGI AND ABD RENEWALS

A 90-day reinstatement period is required for MAGI (including CHIP) and ABD renewal/review closures to allow eligibility to be reinstated retroactively to the effective date of the closure if the recipient is otherwise eligible. The 90-day reinstatement period, defined as 90-days from the effective date of the closure, allows Medicaid or CHIP eligibility to be reinstated without requiring a new application or updated signature.

The 90-day reinstatement period applies to renewal/review closures due to:

- Failure to return the MAGI or ABD renewal form, or
- Failure to comply with renewal requirements by not providing requested information issued in writing on a DOM-307, Request for Information (and DOM-309, Second Request for Information, for ABD purposes).

The 90-day reinstatement period is not associated with other types of reinstatements described in this section that either have no time limits for initiating a reinstatement or may have different time limits. These types of reinstatements are the result of corrective action needed, hearing decisions, known temporary closures for ABD and locating a recipient whose whereabouts were previously unknown.

101.17.02A RENEWAL CLOSURES REQUIRING REINSTATEMENT

Reinstate a MAGI or ABD case that closed at renewal when either of the following conditions exists:

- The case closed due to failure to return the renewal form, and a ***signed*** form (complete or incomplete) is returned within the 90-day period following the effective date of closure; or,

- The case closed due to failure to provide needed information, and the requested information is provided in full or in part within the 90-day period following the effective date of closure.

Effective Month of the Reinstatement

The effective month of the reinstatement is the month following the month of closure. The exception to this rule is if there is a future closure date on file. For future closures, reinstate no earlier than the next calendar month after the current month. For example, if the reinstatement action is taken in July for a child with a closure date at the end of September, reinstate the case with a time period starting no earlier that October 1st.

Requesting Additional Information to Process the Reinstatement

If the renewal form is incomplete or the information provided is incomplete, attempt to handle these issues by telephone contact, if possible. If not possible, issue a DOM-307, Request for Information (and DOM-309A for ABD, if needed), specifying what is needed to comply with the renewal process and allow 15 days for the information to be returned.

- If requested information is ***not*** provided, no further contact with the individual is required unless the information needed is provided during any remainder of the 90-day period. Close the reinstatement contact, delete the time period and document the case narrative.

- If all information is provided, take action to process the case:

    - If eligible, approve using the reinstatement contact providing all eligible coverage.
    - If ineligible due to an eligibility-related reason, i.e., over income, handle as follows:
        - ✓ Cancel the reinstatement contact,
        - ✓ Set an application contact,
        - ✓ Use the 1st day of the month following the closure month as the application date. For example, if the case originally closed at the end of June (06/30), use the 1st of July (07/01) as the application date and the time period begin date.

101.17.02B RENEWAL REINSTATEMENT NOT REQUIRED

A reinstatement is ***not*** required for a renewal closure if the renewal form is returned ***unsigned***.

- Upload the unsigned form in case documents and document the case accordingly,
- Return the unsigned form via a manual 307, Request for Information for both MAGI and ABD renewals, advising the individual the attached form must be signed (Note: a 309 is not issued in this instance if the form is not returned).
- If the signed form is subsequently returned within the 90-day period, handle as instructed in "Renewal Closures Requiring Reinstatement" described above.

101.17.03 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, 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.

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.

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.

101.17.04 CONTINUATION OF BENEFITS AND HEARING DECISIONS

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.

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.

101.17.05 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.

101.17.06 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. Reasonable effort means:

- At least two attempts to contact beneficiary
- Attempt to contact through at least 2 modalities (such as, mail, phone, email)
- If there are not two ways to contact the client on file, document in the case narrative why 2 modalities couldn't be attempted.
- Allow at least 30 days for the beneficiary to respond.

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 and/or CHIP benefits must be reinstated with no loss.

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.

101.18 OTHER CHANGES – ABD PROGRAMS

101.18.01 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.

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 January 31st 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.

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.

101.18.02 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 the system for the following month after the established deadline dates for advance notice.

101.18.03 WOMEN IN HEALTHIER MS WAIVER OR MEDICARE COST-SHARING GROUPS TRANSITIONING TO COE-088 FOR PREGNANCY AND POST-PARTUM ELIGIBILITY

The Healthier MS Waiver (HMW) and Medicare Cost Sharing eligibility groups do not cover pregnancy-related services. If a woman is active in the HMW or as a QMB, SLMB or QI and reports that she is pregnant and needs pregnancy-related coverage, take the following action:

- Obtain her expected due date,
- Using information from her ABD application or last review form, use non-filer MAGI household composition and budgeting rules to determine her eligibility for COE-088,
- If eligible, transition her to COE-088 for the duration of the pregnancy and post-partum period. MEDS will set a review date for the end of her post partum period. Evaluate eligibility for all COEs (ABD and MAGI) when completing her review after the 12 month post partum period.
- If ineligible for COE-088 using non-filer rules, contact the ABD recipient to confirm whether the use of non-filer rules is appropriate. If the recipient is a tax filer or dependent of a tax filer, apply filer rules as appropriate to determine eligibility for COE-088.

- If eligible using filer rules, transition ABD recipient to COE-088 for the duration of the pregnancy and post-partum period. At the end of her post-partum period, the system will automatically transfer her back to her original ABD COE. If her annual review is due or overdue, give priority to completing the needed redetermination of ABD eligibility.
- If ineligible using filer rules or if filer rules do not apply and the ABD recipient is ineligible using non-filer rules, issue a manual DOM-305, Notice of Action, advising the ABD recipient that she is not eligible for Medicaid as a pregnant woman but that she remains eligible in her original ABD coverage group.

101.19 OTHER CHANGES – MAGI PROGRAMS

101.19.01 TRANSITIONING THE PREGNANT CHIP CHILD TO MEDICAID COE-088

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. There is no need to determine if the minor is eligible for Medicaid coverage as a pregnant woman, because pregnant minors have income exemptions that assure eligibility. If pregnant, enter the due date in the system, process eligibility and the child will transition from CHIP to COE-088 Medicaid for the duration of the pregnancy and 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 an adverse action. If action is taken by the 15th of the current month, CHIP will terminate at the end of the current month and the pregnant minor will move to Medicaid COE-088 the following month. If action is taken after the 15th, CHIP will continue for another month before transitioning to Medicaid. 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.
- The child's review due date.
- Information about coverage for a 12-month post-partum period.
- The deemed eligible provision for children born to Medicaid-eligible women.

When the pregnant minor's review comes due at the end of her postpartum period while she is on COE-088, the review will be completed. If the child is eligible for full Medicaid or CHIP, action can be taken to change the child from COE-088 to the appropriate MAGI or CHIP coverage group for a child under age 19 effective with the month following postpartum coverage.

101.19.02 WOMEN IN THE FAMILY PLANNING WAIVER (FPW) TRANSITIONING TO COE-088 FOR PREGNANCY AND POST-PARTUM ELIGIBILITY

The Family Planning Waiver does not cover pregnancy related services. If a woman is active in the FPW and reports that she is pregnant, obtain her expected due date and enter it into the system so that she will transition to COE-088 for the duration of her pregnancy and post-partum period. Since the FPW uses non-filer rules to determine eligibility and non-filer rules would apply to the transition determination, there is no requirement to do a new or updated determination.

101.20 APPLICATION AND REVIEW SUMMARY CHART

ACTION	POLICY REQUIREMENT	PROCEDURAL REQUIREMENTS
Filing an Application, Submitting a Renewal Form, and Reporting Changes	Means of submission: • In-person at any location where eligibility staff are on official duty • By mail to the agency, RO or Central Office (CO) • By fax to the agency (RO or CO) • Applications may be submitted on-line at www.medicaid.ms.gov. • By telephone – The telephonic signature must be recorded. • Applications and renewal forms may be submitted online through the Common Web Portal	Applications & Renewal Forms must be signed but an original signature not required. Telephone signatures are recorded versions.
Who Can File an Application	• Adult applicants • Certain minors (pregnant, married, living independently, applying for own children) • Parent with primary physical custody or either parent if true joint custody exists • Caretaker relative • Authorized, designated or legal representative	If application filed by incorrect person, do not deny; get signature of correct person. Applications must be signed to be valid.
Authorizing a Representative (types allowed)	1) Authorized Representative – applicant or recipient designates in writing. Can be a person or organization. Limits can be placed on rep's rights to act. 2) Self-Designated Rep – must be an individual except for owner/operator of state owned	MAGI application form used to designate authorized rep for MAGI cases. DOM-302A required for ABD authorized rep. Self-Designated requires DOM-302B;

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	LTC facility. Rights are not limited. Applicant must be incapable of designating authorized rep. 3) Legal Rep – legally appointed by court or other legal document (such as POA) and must be legally authorized to make healthcare decisions for applicant/recipient. Can be an executor of deceased applicant's estate.	Legal rep requires DOM-302C.
Filing Date of an Application	The date a signed application is filed or received by the agency (RO or CO) by any means of submission for filing an application.	The date received by DOM or the FFM is the date filed
Medicaid Applications Filed Outside of DOM	1) SSI applications, 2) Children in the custody of DCPS who are certified as eligible by DCPS, 3) Medicaid or CHIP applications filed with the FFM and transferred to DOM, 4) LIS applications filed with SSA and transferred to DOM, 5) HPE applications filed with qualified hospitals and PEP applications filed with providers/entities and transferred to DOM.	DOM determines eligibility for FFM, LIS, HPE, and PEP applications.
RO with Responsibility	RO that serves the county where at-home recipients live is responsible for the case. Long term care cases are handled by RO that serves the county where the facility is located.	Combo MAGI/ABD cases with one in a facility is handled by RO

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		where facility is located.
Timely Processing of Applications (SOP or Standard of Promptness)	• 45 days for MAGI and ABD if no DDS decision needed. • Applications filed with FFM have a SOP beginning with date received by DOM; filing date is date filed with FFM. • 90 days for ABD if DDS decision needed.	Days are counted from date of filing application to decision date, except those filed with FFM.
Making an Eligibility Decision	Verification of eligibility factors comes from data available from electronic data sources and/or the applicant. If data is unavailable from data sources or if applicant provided information is inconsistent, verify independently, which includes obtaining from applicant.	Case documentation is required to support an eligibility decision. Use the Case Narrative or document within the case record.
Issuing Requests for Information (RFI)	ABD applications utilize a 307 (1st RFI) and 309 (2nd RFI). If additional time is requested, hold to end of allowed processing time period applicable. MAGI applications require direct contact 1st, then utilize a 307 (1st RFI). If additional time is requested, hold to end of 45 days.	Refer to "Reasonable Efforts to Assist All Applicants" to avoid multiple denials of eligibility when the applicant is incapable, or rep is unwilling to provide needed information.
Compliance After Denial	If MAGI or ABD applicant fully complies by providing needed information by the end of the month following the month of denial, use denied application and application date and reinstate the application.	

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MAGI Application Indicates Possible ABD Eligibility	If a MAGI applicant indicates possible disability, issue the ABD DOM-300 & request only information not available through MAGI process. A signed ABD application is required. If ABD application is not received, process the MAGI application.	FFM applicants indicating disability are sent a non-MAGI letter that must be signed & returned to start ABD process.
Determining Beginning Dates of Medicaid Eligibility	If all factors of eligibility are met, the begin date is: • 1st of month of application, or • 1st day of the 1st, 2nd or 3rd month prior to the month of application. • QMB eligibility begins no earlier than the month following the month of approval. • HPE and PEP eligibility begins on the day of the month the hospital determines an individual to be eligible for HPE and providers/entities determine an individual to be eligible for PEP.	Retroactive Medicaid does not have to be authorized at the time of application. It can be requested and added at any point in time.
Determining Beginning Date of CHIP Eligibility	• 1st of month following month of application eff. 12/01/2016 • If a newborn application is taken within 31 days of birth and approval is authorized within 60 days of application, CHIP eligibility is retroactive to the date of birth.	There is no retroactive eligibility for CHIP eligible children, except newborns.
Determining End Dates of Eligibility	For Medicaid and CHIP, the end date of eligibility is either: • The last day of the month that eligibility ends, • The death date of the recipient,	

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	• The date of entry into a public institution. • HPE and PEP ends the last day of the month of the HPE and PEP period or the actual day of the month that the full application for Medicaid is denied.	
Filling in the Gap for SSI Eligibles	Missing months of SSI eligibility may be evaluated with the application for retroactive Medicaid or under a separate application at a future date. SSI payments begin the month following the month of application. The month of application is the E02 month.	DOM covers the E02 month automatically since SSI determines the person eligible for the E02 month.
Processing Applications & Renewals of DOM Employees & Family Members	Medicaid or CHIP cases involving DOM employee family members may not be handled directly or indirectly by the DOM employee with the family relationship.	Assigned Central office staff is responsible for processing applications and renewals.
Ensuring Continuous Eligibility for Children under Age 19	Children determined eligible at the time of application and renewal are locked into a protected period of eligibility for 12-full months. Only a limited number of early termination reasons can interrupt the 12-months of continuous eligibility.	Applies to both MAGI-related children and ABD children
Ensuring Eligibility for the 1st Year of Life for the Deemed Eligible Infant	An infant born to a Medicaid-eligible mother is eligible from the date of birth through the month the child reaches age one (13 months).	Central Office staff inputs deemed eligible infant eligibility upon direct notification by

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		the birthing hospital.
Assigning Review Due Month at Application	MAGI – Medicaid application month starts the 12-month count. MAGI – CHIP benefit month starts the 12-month count. MAGI application month (Medicaid) or benefit month (CHIP) + 11 months = review due date. MAGI -Pregnant Post-Partum review will be set for 12 months after the pregnancy ends. ABD – month of supervisor authorization starts the 12-month count ABD authorization month + 11 months = review due date.	
Assigning Review Due Month at Redetermination	MAGI and ABD are determined using the time period begin month to start the 12-month count. Begin month of time period + 11 months = review due date.	
Administrative Renewal Processing	If eligibility can be *approved* in the same program (Medicaid or CHIP or ABD in the same COE) based on updated data from electronic data sources and reliable case record information, then the recipient is notified of the approval and asked to report any changes. Any changes reported are acted on as part of the redetermination process.	ABD cases with an asset test can be renewed through this process. Adm. renewals must be initiated before scheduled mailings of pre-populated forms.
Processing Renewals Using Pre-Populated Review Forms	Pre-populated renewal forms are issued by MEDS for MAGI & ABD cases. Due date for return of the signed form MAGI and ABD form is 30- days from date form is issued. Returned forms with missing information require the use of a309 for ABD and telephone contact for MAGI. New or	Refer to the Reinstatement policy for compliance after termination.

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	additional information requires use of 307 (MAGI) and 307/309 (ABD). Must attempt telephone contact prior to terminating (for MAGI and ABD) to try to secure missing information.	
Timely Authorization of a Renewal	Review is timely if authorized by the last day of the month in which review is due. If case is closed, action to close must be authorized by the adverse action deadline date.	Reviews are considered overdue if not authorized timely.
Adverse Action Deadline(s) for Advance Notice	Advance notice (10-days) is required to take an adverse action. The deadline is the 15th day of the current month (exception is February – deadline is the 13th) to allow 10-days advance notice plus 5-days mailing time.	Adverse action must be authorized ***on or before*** the deadline date to be effective the following month.
Advance Notice to Reduce or Terminate Benefits	Advance notice is required to: • Terminate eligibility • Convert a case to a reduced services COE (QMB, SLMB, QI) • Terminate a nursing facility per diem payment • Switch from CHIP to Medicaid or Medicaid to CHIP	Advance Notice = 15 full days following the date an adverse action is taken on a case. Medicaid Income increase is the exception.
Advance Notice to Increase Medicaid Income	Advance notice is 10-days before the date DOM makes its payment to the nursing facility, which is always in the month following the current month.	Advance notice is 10 calendar days before the 1st of the following month for the change to be effective

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		in current month.
Requirement for Ex Parte Reviews	Any recipient losing eligibility in one COE must be reviewed under any/all available COE's using existing information prior to terminating eligibility. If additional information is needed, allow a reasonable opportunity to provide additional information which may include a separate application form (ABD to MAGI & vice versa).	If recipient is being terminated for failure to comply with the renewal process, an ex parte review is not applicable.
SSI Terminations Due to Excess Income or Resources	These types of SSI terminations are issued an SSI Redetermination Form for possible eligibility in a Medicaid COE. An abbreviated review form is issued by the system. Continuing eligibility is decided using the completed review form along with data on the SDX and SVES records. If additional information is needed, contact with the individual may be required.	An SSI renewal is a type of ex parte review; however, all factors of eligibility must be verified.
Renewal Processing	MAGI and ABD renewals may be returned to the RO by any means allowed for submission of an application.	Telephone renewals that are not recorded must be sent to the recipient for signature.
Renewals and 12-Months of Continuous Eligibility for Children	Children in a case may have different review due dates. Attempt alignment of review dates at the time of renewal if possible but continuous eligibility cannot be shortened (without a written request from the parent/caretaker). A new period of continuous eligibility can be assigned when	Children require a full review at the end of their 12-month protected period of eligibility; future end dates

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	eligibility is reestablished for all HH members.	are not permitted.
Special Reviews due to Reported Changes	Reported changes that result in a negative action for adult(s) in the case cannot affect eligibility for children in the case. Reported changes that will not affect eligibility for the household must be acted on, but do not terminate eligibility if a request for information yields no response. Children must be reviewed at the end of their 12-month review period; no future closure dates are permitted. Changes from CHIP to Medicaid must be acted on.	Reported changes resulting in updated information on all household members can result in a new annual review period for the HH.
Reinstatements Due to Failure to Issue Advance Notice	If advance notice was not issued as required to reduce benefits or terminate eligibility, reinstate eligibility for all affected months then issue advance notice to terminate or reduce benefits.	Reinstate regardless of whether HH or individual is eligible to remedy failure to issue advance notice.
90-Day Reinstatement Period for MAGI & ABD	Compliance within 90-days following effective date of closure to return the signed renewal form and/or provide requested information will result in reinstatement back to the date of closure. If additional information is needed, attempt telephone contact 1st, then use 307 (MAGI/ABD) and 309 (ABD). • If information not provided, no further action required except to close the reinstatement contact & delete time period.	This rule is not applicable for the return of unsigned renewal forms.

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	• If information provided & eligibility is established, approve reinstatement. • If information provided & ineligibility exists, cancel the reinstatement & set an application contact. Refer to policy for details.	
Corrective Action Requirements	If corrective action adversely affects a recipient, handle via completion of an Improper Payment Report. If corrective action favorably affects a recipient, handle as a reinstatement back to the month the error occurred.	There is no time limit imposed for corrective action.