MA-2352 TERMINATIONS/DELETIONS/EX PARTES

REISSUED 08/01/13 – CHANGE NO. 05-13

I. POLICY PRINCIPLES

Whenever an individual is determined ineligible for Medicaid in **any aid program/category** he must be evaluated for ongoing Medicaid eligibility. Complete an evaluation to determine if the individual is eligible for any other aid program/category before terminating any Medicaid coverage for the aged, blind or disabled. The evaluation is to include Medicaid for the Aged, Blind, and Disabled (MAABD), including HCWD, MQB-Q, MQB-B, MQB-E, Qualified Disabled Working Individuals, NC Health Choice and Family and Children's Medicaid. Refer to III. below for exceptions to this policy.

The term "ex parte review" means to review information available to the agency to make a determination of eligibility, without requiring the beneficiary to come into the agency or make a separate application. A signed redetermination document is not required for an "ex parte review." The county must explore and exhaust all possible avenues of eligibility in **all** Medicaid coverage groups as well as NC Health Choice for Children. If information is not available to make a determination of eligibility, the county must provide the beneficiary reasonable opportunity to provide the necessary information.

When reviewing ongoing Medicaid eligibility, if you establish eligibility in an aid program/category that requires the creation of a case in EIS, a signed application is not required. Enter the DSS-8124 as an administrative application or reapplication.

For example: MAD case is terminating due to no longer considered disabled. Evaluate the case for any other Medicaid coverage group, including HCWD Medically Improved Coverage, or NC Health Choice before terminating case. Client has a child in the home under 18 years old receiving Medicaid. Caseworker found the client is eligible for Medicaid for Families (MAF). The county should not require a signed application. Enter the DSS-8124 as a new administrative application.

Always send appropriate notice before termination.

(I)

A. Exceptions

Refer to III below for the exceptions to continuing Medicaid when Medicaid, (both adult and family and children) including Work First, terminates.

B. Medicaid Ineligibility

When a individual is determined ineligible in a **Medicaid only** aid program/category, continue his authorization until he is determined eligible or ineligible for ongoing Medicaid in all other aid program/categories.

1. The aid/program categories include all Adult Medicaid categories, Family and Children's categories, as well as NC Health Choice. This includes the MQB's, and Qualified Disabled Working Individuals.

2. This may be an ex parte or a redetermination. See II. below.

C. Ongoing Medicaid Eligibility

When the ex parte review or redetermination is completed and ongoing Medicaid eligibility is established, authorize the individual for the appropriate aid program/category. MAABD authorization requires an unsigned administrative new application if ineligibility was in a Family and Children's Medicaid aid program/category. Follow policy rules to determine the appropriate certification period.

Example: MAD case at redetermination is found to no longer meet the definition of disability and does not meet the eligibility requirements for HCWD. Individual is eligible for MAF as caretaker due to a child receiving Medicaid in the home. This requires an unsigned administrative new application.

II. WHEN MEDICAID TERMINATES

A. Any time it is determined that an individual is ineligible for Medicaid including Medicaid received under Work First, SSI, or State/County Special Assistance, the caseworker must evaluate each ineligible individual to determine whether he is eligible for Medicaid in any other aid program/category or NC Health Choice**. DO NOT TERMINATE MEDICAID UNTIL A DETERMINATION IS MADE, AND THE TIMELY NOTICE PERIOD HAS EXPIRED.**

1. When Work First terminates, refer to Family and Children's Medicaid Manual Section MA-3355 for steps to follow in determining ongoing Medicaid eligibility.

2. When SSI terminates, refer to MA-1000.

3. When State/County Special Assistance (SA) terminates, follow policy in this section to determine ongoing Medicaid eligibility prior to termination of SA.

(II.)

B. An ex parte review is required when Medicaid ineligibility is established due to a change in situation.

C. A full redetermination must be completed when Medicaid ineligibility is established at the end of the following situations:

1. Medicaid certification period, or

2. MPW postpartum period (Refer to Family and Children's Medicaid Manual Section MA-3240, Pregnant Woman Coverage), or

3. Work First payment review period (Refer to Family and Children's Medicaid Manual Section MA-3410, Terminations and Deletions).

4. State/County Special Assistance payment review period.

This means a signed redetermination document is required. Refer to II.E. below.

D. Ex Parte Review

1. Whenever a change in situation causes an individual to become ineligible for Medicaid or Work First, complete an ex parte review to evaluate for Medicaid in any possible aid program/categories. Refer to III., below for the exceptions. The possible aid categories are listed below. Citizenship/identity documentation is not required during an ex parte review.

   a. Aged, Blind and Disabled Medicaid

   (1) MAA when anyone in the assistance unit is age 65 or older.

   (2) MAD when anyone in the assistance unit receives Social Security disability, or there is a DMA-4037 , Disability Determination Transmittal, in the record indicating that an individual has been determined disabled and the disability has not been subsequently denied or terminated.

   (3) MAD when a MAD beneficiary's Social Security or SSI disability is terminated due to not being disabled and he has requested an appeal of the disability denial or termination through Social Security. Refer to MA-2525, Disability and MA-1000, SSI Medicaid – Automated Process.

   (4) MAD for SSI children with protected status. Refer to MA-2525, Disability.

   (5) MAB when anyone in the assistance unit meets Social Security's definition of blindness.

(II.D.1.a.)

(6) HCWD when anyone in the assistance unit is disabled and working. Refer to MA-2180, Health Coverage for Workers with Disabilities.

(7) MQB-Q, MQB-B and MQB-E, when one is enrolled in Medicare Part B. Coverage is limited to partial or full payment of Medicare premium, deductibles and co-insurance. Refer to MA-2130, Qualified Medicare Beneficiaries-Q, MA-2140, Qualified Medicare Beneficiaries-B, MA-2160, and Qualifying Individuals.

(8) MWD (Qualified Disabled Working Individual) when one is eligible for Medicaid payment of Medicare Part A premium after automatic entitlement to free Part A ends. Refer to MA-2150, Medicaid-Working Disabled.

b. Medically Needy

If the individual is ineligible under categorically needy requirements, evaluate eligibility for medically needy under all coverage groups in which he can be included.

(1) If the individual is eligible for Medicaid but must meet a deductible, contact the beneficiary regarding his old, current and anticipated medical expenses to determine if he can meet the deductible. The deductible can be met if:

(a) His deductible amount is $300 or less, or

(b) His old, current and anticipated medical expenses are within $300 of meeting the deductible.

(2) Follow EIS instructions to establish the necessary case.

(3) If it is determined that the individual's deductible is greater than $300 or his old, current and anticipated medical expenses are not within $300 of meeting the deductible, send timely notice to propose termination.

c. Family and Children's Medicaid

(1) MAF-C including,

(a) MAF-C for Job Bonus (MAF-C), refer to Family and Children's Medicaid Manual, Section MA-3300, Income. Ensure you evaluate under both budgeting methodologies in MA-3300, Income.

(II.D.1.c. (1))

(b) MAF-C, refer to Family and Children's Medicaid Manual, Section MA-3405, Twelve Month Transitional Medicaid.

(c) Caretaker relative of an individual under age 19.

(d) Expanded Foster Care Program, (EFCP), refer to Family and Children's Medicaid Manual, Section MA-3230, Eligibility of Individuals Under Age 21.

(2) Four Month Transitional Medicaid (AAF payment type 4). Refer to Family and Children's Medicaid Manual, Section MA-3400, Four Months Transitional Medicaid.

(3) MIC-N for individuals under 19.

If a Work First beneficiary turns 18 and has protected SSI status, transfer the child to MIC and begin the adult disability review process. Refer to MA-2525, Disability.

(4) 12 month continuous eligibility for individuals under age 19 (MIC) if ineligible for any other categorically needy Medicaid coverage group and there are months remaining in the 12 month period since the last determination.

(a) If more than 2 months remain in the 12 month continuous period following Work First termination, authorize for the remainder of the 12 months.

(b) If 2 or fewer months remain in the 12 month continuous period following Work First termination, evaluate for NC Health Choice and Medically Needy coverage following the two month period.

Do not terminate categorically needy coverage until after a timely notice is sent.

The 12 month continuous period should be documented in the case record at application and at each redetermination.

(5) NC Health Choice for individuals under age 19. If there is a freeze on the NC Health Choice program, follow the policy regarding actions to be taken during the freeze.

(II.D.1.c.)

(6) MAF-N when anyone in the assistance unit is ages 19 – 20.

(7) MPW if it is known to the agency that the beneficiary is pregnant. Refer to Family and Children's Medicaid manual MA-3240, Pregnant Women Coverage.

If medical verification of the pregnancy is not in county records, contact the beneficiary to request verification of pregnancy to evaluate for MPW. Send the DMA-5137, Ex Parte Verification of Pregnancy. Allow 12 calendar days to provide verification of pregnancy. If more time is needed to get the verification, allow an additional 12 calendar days.

(8) If there is no information to indicate pregnancy, continue to evaluate in other coverage groups.

(9) MAF-D, Medicaid Family Planning Waiver (FPW) for women aged 19 through 55 or men aged 19 through 60. Refer to MA-3265, Family Planning Waiver Medicaid.

(10) MAF-W, Breast and Cervical Cancer Medicaid for women diagnosed with breast or cervical cancer through the BCCCP program. Refer to MA-3250, Breast and Cervical Cancer Medicaid.

d. Refugee Medical Assistance (RMA)

If the individual is a refugee and not eligible under any aid program/category, refer to the RMA manual.

2. Begin the evaluation for ongoing Medicaid as soon as it is determined that the family/individual is ineligible.

3. Do not require a signed application or redetermination document.

4. Unless questionable, consider information obtained and verified by the other program within the time frames for redeterminations of eligibility for the Medicaid coverage group being considered.

5. Verification Requests:

a. Reverify only those eligibility factors that are subject to change: such as;
(1) Income,
(2) Household composition or
(3) Resources

(II.D.5.)

b. Do not re-verify factors that are not subject to change, such as
   (1) Date of birth
   (2) Citizenship.

c. Information must be obtained from a case that
   (1) Is active or
   (2) Is a pending application within the DSS agency or
   (3) Is an FNS case in suspense

d. The information must be current. Current information means it was obtained and verified:
   (1) In another program or
   (2) In another Medicaid case and
   (3) Within the time frames for redeterminations of eligibility for the Medicaid coverage group being considered. Time period is determined by the certification period for the program being evaluated. These time frames apply to all sources of information, including SDX.

   For example, if the beneficiary is being evaluated for MAF Medically Needy and the certification period is 6 months, the information must have been verified within the last 6 months. If the beneficiary is being evaluated for MIC and the certification period is 12 months, the information must have been verified within the last 12 months. In both of these situations the other program must be active, pending or an FNS case in suspense at the time the information is obtained.

e. Information obtained from a closed or terminated program can not be used even if verified during the appropriate time frames

f. Available to the agency includes information available through automated queries, such as:
   (1) THE WORK NUMBER
   (2) SDX
   (3) BENDEX
   (4) OLV
   (5) FSIS
   (6) SOLQ
   (7) ESC or
   (8) Other reliable internet based sources of employment and wage verification. (Refer to MA-3515, Automated Inquiry and Match Procedures, and EIS Manual 1100 Volume I for instructions on using the SDX, BENDEX and other online inquiries.)

(II.D.5.)

g. Information collected in the determination of eligibility for other programs if the information can be released by the other programs within its rules for confidentiality, such as:

(1) Food and Nutrition Services
(2) Work First
(3) Child Care Assistance
(4) IV-D- Child Support Services
(5) Adult or Children Services

h. If the names of immediate family members (spouse, parents and stepparents, adult or minor children, and siblings) who live with the individual are known, check all records in their names and complete on-line matches. See DMA-5138, Non MIC/NCHC Ex parte Checklist and the DMA-5075, Verification Checklist for MIC/NCHC Re-enrollments. for a checklist to document family members.

i. Contact the casehead if additional verification is needed which is not available to the agency. Contact may be by telephone or in writing. If a telephone request is made, advise the casehead what information is needed and that he may request additional time or assistance in obtaining necessary information.

j. Document the record to show the date of the telephone contact, the specific information requested and that the beneficiary was offered assistance. If the request is in writing, use the DMA-5097, Request for Information.

(1) Explain to the casehead that he is responsible for providing necessary verification within 12 calendar days of the request. If the casehead needs more time, allow another 12 calendar days.

(2) If verification is not received, send a timely notice proposing termination for failure to provide necessary information. Failure of the caretaker to return requested information does not affect continuous eligibility for the children.

(3) Timely notice can be sent no earlier than the workday following the due date on the DMA-5097, Request for Information.

(4) Do not terminate an individual for failure to provide information unlikely to change or for information that is available to DSS.

6. If the entire case or individuals in the case are ineligible for ongoing Medicaid in any aid program/category including Adult Medicaid or NC Health Choice, document the record and send a timely notice to terminate Medicaid.

7. If ongoing eligibility is established, continue with the remainder of the current certification or payment review period or a new certification period if needed. A new certification period is needed if the current one has expired. The length of the new certification period is based on the category.

8. If eligibility cannot be established in the time frame, extend eligibility one month at a time until eligibility is established for all aid program/categories. Ensure the appropriate notice is mailed prior to termination.

E. Medicaid Redetermination

1. Complete a full Medicaid review with a signed redetermination document prior to the end of the Medicaid certification period or MPW postpartum period or Work First payment review period. As for all cases, the case management will display that a review is due beginning 2 months prior to the end of the certification/payment review period.

2. Follow instructions in MA-2320, Redetermination of Eligibility, or Family and Children's Medicaid Manual, Section MA-3420, Re-Enrollment, to determine ongoing eligibility in all Medicaid categories and NC Health Choice.

III. EXCEPTIONS TO CONTINUING MEDICAID WHEN MEDICAID, INCLUDING WORK FIRST TERMINATES.

When an individual becomes ineligible for one of the following reasons, do not evaluate for on-going Medicaid.

A. Terminate Medicaid for individuals when ineligibility is for one of the following reasons:

1. Moved out of state,

2. Individual is deceased,

3. Casehead voluntarily requests termination of Medicaid and/or Work First,

   a. The request must be in writing and specifically request Medicaid termination. If it is a Work First case the casehead must specifically request termination of Medicaid as well as Work First.

   b. File the written request in the case record. The record must include documentation that the individual understood that he and/or the children may still be eligible for Medicaid and chose not to continue.

(III.A.3.)

c. If the request is for Work First termination and there is no written request for termination of Medicaid, authorize for MAF-C through the remainder of the Work First payment review period or 2 months, whichever is greater. Complete an ex parte review to determine ongoing Medicaid eligibility prior to the end of the certification period.

4. Individual is incarcerated in a federal prison, state juvenile justice facility, county or local jail (refer to MA-2510, Living Arrangement for instructions),

Note: The eligibility of individuals incarcerated in North Carolina Department of Public Safety, Division of Prisons (DOP) facilities, or of those age 21 thru 64 in institutions for mental disease, is placed in suspension if they remain otherwise eligible. (see MA-2510, Living Arrangement for instructions).

5. Unable to locate,

a. Document all reasonable attempts to locate the individual. This includes searching all other agency records, both paper and computer records. For example, search Food Stamps, ACTS, Service Records (Child Care, etc.), ESC, SDX, SOLQ and EPICS.

b. If the most recent address is not current, attempt to locate a telephone number to contact the individual. A current address is:

(1) Part of an active record in another program (such as Food Stamps, services or IV-D records).

(1) Part of an inactive record in another program which had active benefits, or eligibility for benefits within the past 6 months. Any activity in the case in the previous 6 months, except for mail returned as undeliverable, is sufficient to consider the address current.

(3) From any source in the agency, if no older than 6 months. This includes Food Stamp denials. Check other available records such as ACTS, Service Records, Child Care, ESC, SDX, EPICS, etc.

(4) From any source outside the agency if no older than 6 months.

c. If the location of the payee is unknown, but you know the child(ren)'s location, authorize the child(ren) for Medicaid.

(III.A.)

6. Failure to cooperate with IV-D and good cause can not be established. This applies to caretaker applying for or receiving Medicaid for herself only. Refer to MA-2375, Procedures for Child Support Enforcement, when the adult beneficiary is pregnant.

7. The only person receiving Work First Family Assistance has been approved for SSI benefits or,

8. Failure to complete or provide information for a Medicaid redetermination review. This is not a Work First review,

9. Failure to apply for benefits to which entitled.

B. Instructions to Terminate

1. Document the reason for the termination in the case record. It must be one of the exceptions listed in III. above.

2. Refer to the EIS User's Manual for the correct termination/deletion code to generate an automated notice. Never use "OTHER".

C. After Medicaid Case is Terminated

1. Once Medicaid is terminated, follow MA-2304, Processing The Application, for reopening this case within 30 days of termination.

2. Refer to MA-2304, IV.D, Processing The Application, for procedures for determining if the case may be administratively reopened.