

North Carolina Department of Health and Human Services
Division of Medical Assistance
Medicaid Eligibility Unit

AGED, BLIND AND DISABLED MEDICAID MANUAL

MA-1000

SSI MEDICAID – AUTOMATED PROCESS

REVISED 03/02/2023 – CHANGE NO. 03-23

I. INTRODUCTION TO SSI MEDICAID

North Carolina contracted with the Social Security Administration (SSA) under Section 1634 of the Social Security Act to determine Medicaid eligibility for aged, blind, and disabled individuals who receive SSI. This contract is called a “1634 Agreement” and was effective January 1, 1995. Under this agreement, an application for SSI is also an application for Medicaid. Individuals who are eligible for SSI also qualify for Medicaid. Eligibility for Medicaid begins with the first day of the month in which eligibility for SSI begins and continues as long as the individual remains eligible for SSI.

The SSA determination of SSI Medicaid eligibility includes assessment of categorical requirements, citizenship, income and assets, identification of third party resources and fraud notification. The Eligibility Information System (EIS) issues Medicaid cards and automated notices for these recipients. This is done independently from the issuance of the SSI check. The majority of SSI recipients receive Medicaid without any county dss action or intervention. However, there are special situations which require the county dss to explain and provide services and assistance to SSI Medicaid recipients.

When the SSI terminates, Medicaid may continue without a separate application. The SSI termination appears on the SSI TERMINATION REPORT and the Medicaid remains open. The county department of social services (dss) is responsible for initiating an ex parte review to determine whether the recipient qualifies for Medicaid under any other coverage group, such as Family and Children's Medicaid (including pregnant woman coverage), North Carolina Health Choice for Children, Work First Family Assistance, or Medicaid for the Aged, Blind and Disabled.

The purpose of this section is to explain the automated process which generates Medicaid eligibility based on SSI.

II. POLICY PRINCIPLES FOR SSI MEDICAID

- A. SSI recipients are eligible for Medicaid based on receipt of SSI.**
- B. Ongoing Medicaid eligibility is determined by the Social Security Administration (SSA) for SSI recipients.**
- C. EIS automatically issues Medicaid benefits and notices to SSI recipients based on receipt of SSI.**

(II.)

D. The county dss evaluates Medicaid eligibility for SSI recipients when the SSI benefit terminates. The county dss must explore and exhaust all possible avenues of eligibility in other aid program/categories.

When the SSI termination is based on no longer being disabled and the SSI recipient timely appeals the SSI decision, his disability status continues through the SSI appeals process. Continue Medicaid benefits as long as he meets non-disability criteria through the SSA appeal process. Refer to MA-2525, Disability, for timeframes on appeals.

Refer to VII.D., Continuation of MAD When SSI Disability Termination is in Appeal Status for ex parte procedures. The recipient also has the right to appeal to a State Hearing Officer on the issue of disability if the ex parte process finds him no longer eligible for Medicaid.

If the recipient has a non-disability SSI change that results in ineligibility, he may continue to be eligible as MAD or cease to be eligible as MAD. The county dss must explore and exhaust all possible avenues of eligibility in other aid program/categories.

III. AUTOMATION OVERVIEW**A. State Data Exchange (SDX)**

SSA transmits information regarding SSI recipients and applicants to the State using the SDX. The State uses information on the SDX to create a Medicaid record in EIS for each SSI recipient. The SDX controls Medicaid eligibility for SSI recipients. Except for the situations identified later in this section, only the SDX can update information in EIS for an SSI recipient. This is true even when the county dss has verified information that is inconsistent with the data on the SDX.

Social Security sends SDX updates to the State several times a week. The updates are compiled and processed once a week for Medicaid issuance for SSI recipients. Generally the updates are run on Friday night.

The on-line SDX is updated daily as updates are received from Social Security. Therefore, it is possible for an individual to be on the SDX before he is in EIS.

B. EIS Uses Information on the SDX To:

1. Create an SSI MAABD case (or modify an existing Medicaid case in EIS to SSI Medicaid).
2. Update case and individual data in EIS for ongoing SSI Medicaid recipients.
3. Issue automated approval, denial, termination and redetermination notices.
4. Issue Medicaid cards for SSI recipients.

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(III.B.)

5. Terminate Medicaid when an SSI recipient dies or moves out of state.
6. Change to SSI status when SSI stops.

C. SSI Medicaid Recipients In EIS

An SSI Medicaid case is in EIS just as a regular Medicaid case is in EIS, with case and individual data and history.

1. SSI Status
 - a. SSI Medicaid Recipients - The SSI status is "Y" for SSI recipients. EIS/SDX controls most of the data on these cases. See III.D., below or refer to the EIS Manual, Section 4200, Part 5.
 - b. SSI Medicaid Recipients In Ex Parte Review Status - The SSI status is "N" and the "Certification Thru Date" is 12/31/9999. Do not make changes to the case in EIS until the ex parte review is completed.
 - c. Non-SSI Medicaid Recipients - The SSI status is "N" for non-SSI recipients. The county dss controls all data on these cases.
2. Aid Program/Category

The aid program/category is always MAA, MAB, or MAD except for the following situations:

 - a. SSI recipients who also receive Special Assistance are SAA or SAD.
 - b. SSI children in foster care are HSF.
 - c. SSI recipients in a single person Transitional Medicaid case (payment type 5) remain AAF.
3. Classification

SSI recipients are always Categorically Needy. The classification code in EIS is:

 - a. "C" for SSI recipients who do not have Medicare, or
 - b. "Q" for SSI recipients who are entitled to Medicare.
4. Individual Eligibility History (IE)
 - a. The IE segment indicates the individual is an SSI Medicaid recipient beginning with the first month of SSI.
 - b. The certification thru date is always 12/31/9999.

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5. ID Cards

All SSI recipients receive a gray Medicaid card. For MAABD cases in a private living arrangement (pla), the district number is “SDX” on the EIS case and ID card to indicate the individual is an SSI Medicaid recipient. SAA, SAD, AAF, HSF, and LTC cases retain the district number assigned by the county dss.

D. Creating/Updating an SSI Medicaid Case in EIS

For all SSI recipients, EIS uses information on the SDX to create and update SSI Medicaid cases in EIS. The county dss cannot change data in EIS for SSI recipients, with certain exceptions. (Refer to EIS 4200, Part 5, for a chart which shows all allowable county changes.) This is true even when the county dss has verified information that is inconsistent with data on the SDX.

1. SSI, MAA, MAB, or MAD recipients:

The county dss can update the following fields in EIS:

- a. Change the living arrangement from private living arrangement (PLA) to long term care (LTC) and from LTC to PLA.
- b. Transfer the case to HSF.
- c. Approve a reapplication for money payment (SAA, SAD, AAF).
- d. Enter CAP date.

Refer to EIS 4200 Part 5, for instructions.

2. SSI Recipients in Special Assistance (SAA or SAD) or in Single Person AAF case (payment type 5)

The county dss can update some fields in EIS to control the issuance of the check and ensure automatic Medicaid issuance for SSI recipients in these categories. The county dss can also transfer the case to MAABD. Refer to EIS 4200 Part 5, for instructions.

3. SSI Recipients in HSF

The county dss can update some fields in EIS to indicate custody/placement responsibility. The county dss can also transfer the case to MAABD. Refer to EIS 4200 Part 5, for instructions.

(III.)

E. Reporting Changes

1. SSI recipients must report to Social Security all changes that affect SSI (including change of address). When Social Security updates the SDX, the change is reflected in EIS. If an SSI recipient reports a change to the dss, instruct him to report the change to the local Social Security Office. Explain that his Medicaid record can only be changed by SSA. Give him the address and phone number of the district office. **DO NOT REPORT ROUTINE CHANGES TO SOCIAL SECURITY. IT IS THE RECIPIENT'S RESPONSIBILITY.**
2. SSI recipients in LTC, SAD, SAA, HSF, or AAF payment type 5 (situations where the county dss has the capability to update some fields in EIS) must also report changes that affect Medicaid to the county dss. When changes are reported, treat this as change in situation. Update the allowable fields in EIS.
3. When an SSI recipient reports health insurance information to the dss, complete a DMA-2041, Third Party Health and Accident Resources Information. Enter this information in EIS. If the recipient does not have enough information to enable you to complete the DMA-2041, instruct him to obtain the additional information and advise him to contact you with the information as soon as possible.
4. When an SSI recipient also receives Food Stamps or other DSS services, notify the other program immediately of any changes the recipient reports to you.
5. When the dss learns of a change in an SSI Medicaid recipient's situation that might affect his eligibility for SSI and Medicaid, and the client does not/cannot report the change to SSA, use the DMA-5049, Referral to the Local Social Security Office, to report information to the local SSA office. Use this referral only when SSA is not aware of the change in situation. Examples of when to use this referral:
 - a. DSS learns SSI recipient dies
 - b. SSI recipient enters a public institution, nursing facility, or rest home
 - c. DSS learns information that affects SSI payment
 - d. DSS suspects fraud
6. The county dss may discover information on the SDX is incorrect. The information may not affect SSI eligibility, but it may cause a problem with Medicaid claims, buy-in or some other factor that affects Medicaid eligibility. Use the DMA-5049, Referral to the Local Social Security Office, to report this information immediately to SSA. Use "Other" to specify the problem. SSA must correct its record in order for the SDX to update EIS. For example, the dss verifies an individual is age 64 or less, but the SDX indicates he is 65. Medicaid claims will be denied until the problem is corrected.

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(III.E.)

7. In the unusual situation that SSA does not react to changes reported by the client or dss and it is causing a hardship for a recipient or provider, contact DMA, Medicaid Eligibility Unit. A policy consultant will work with you on a case by case basis.

F. Buy-In

SSI recipients who are eligible for Medicare are automatically accreted for buy-in by SSA. Buy-in is effective the first month of Medicaid eligibility. SSI recipients remain on buy-in until Medicaid is terminated. See MA-2410, Medicare Enrollment and Buy-In.

IV. SSI APPROVAL

When SSI is approved for an individual, the information on the SDX is matched to EIS to determine if the SSI individual is already in EIS. The purpose of matching is to prevent duplicate EIS individual ID's and benefits. If the individual is not in EIS, EIS creates a new case. If the individual is found in EIS, EIS creates a new case for the individual and closes or deletes him from the existing case, or in some cases modifies the existing case. Refer to EIS 4200, Part 3 for information. Also follow instructions in MA-1100, SSI Medicaid/County DSS Responsibility for county dss responsibility when an active Medicaid recipient or applicant in EIS is approved for SSI.

When the Social Security Number of an individual on the SDX matches with an individual in EIS but one of the other criteria does not match or the social security number is found more than once in EIS, EIS creates an exception report called the "SDX Exception List" which is online in EIS. The county dss must determine if the individuals are the same. It is very important to work the exception report weekly. See EIS 4200, Part 2 for instructions to resolve the discrepancies. **UNTIL THE DISCREPANCY IS RESOLVED, EIS CANNOT PROCESS THE SSI MEDICAID CASE AND/OR ISSUE MEDICAID.**

A. Reports

To assist with case management, EIS generates the report "SSI Medicaid Created/Modified in EIS" when a current EIS case or individual is modified as a result of an SSI approval, and when an SSI Medicaid case transfers into a county. These reports are displayed in NCXPTR. The last six versions are kept on-line. Each situation is identified separately. The EIS county number, district, aid program/category, casehead, case number, case id, SSI recipient name, and individual ID number are listed for each case. Any pending action deleted by EIS as a result of a case termination is also listed.

Refer to EIS 4200, Part 8 for instructions for this report.

See below for a chart of all the SSI Medicaid reports.

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(IV. A.)

SSI REPORTS

Name of Report	What It Lists	Sorted By	Online or Paper
SSI Medicaid Cases Created/Modified by EIS	Cases created/modified/terminated by EIS due to SDX Updates 1) Case Terminated 2) Individual Delete 3) SSI Medicaid 4) Review 5) New Individual 6) County Transfer 7) Inactive	County, District, message type, and alpha by last name	NCXPTR – last 6 versions
SSI Individual In EIS Pending Application	SSI Individual who had a pending application in EIS but now authorized for SSI Medicaid	County, District, and date of application (oldest first)	NCXPTR – Applications listed are retained on the report until dispositioned
SSI/Medicaid ID Registers SSI Medicaid Straggler Run/Register	Cards generated for SSI Medicaid recipients 1) Annual Run 2) Daily/Weekly Straggler	Alpha by name	NCXPTR – last 25 versions
SSI Approval-Medicaid Denied (TPR Refusal)	Denied due to failure to provide TPR info – SDX code - R	County, alpha by name	NCXPTR – last 8 versions
Medicaid Terminated – (TPR Refusal)	Medicaid terminated due to failure to provide TPR info – SDX code – R	County, District, program, and alpha by name	Paper mailed to the county
SSI Individual Receiving SAA/SAD/HSF	List of cases where client failed to provide TPR info, SDX code – R	District, program, alpha by name	Paper mailed to the county
SSI Exempt	Persons exempt from participation in Carolina Access	Exempt #, alpha by name	Paper mailed to the county
SSI Termination Report	Termination due to redetermination, death, moving out of state	District, post date, type action	NCXPTR - Case continues to display until the county processes the termination and deletes the case
SSI Termination Alert Report	The county has not redetermined eligibility, terminated the case, SSI has not been reapproved or a reapplication has not been dispositioned.	County, post date, alpha name	NCXPTR – Case continues to display until the county processes a redetermination.

(IV.)

B. Approval Notice

When SSI is approved and an SSI Medicaid case is created in EIS, an automated Medicaid approval notice is generated that night. See DMA-5101, SSI Approval Notice.

C. Medicaid Card Issuance

1. For new SSI approvals, EIS issues Medicaid cards for SSI Medicaid approvals the same night the case is created in EIS. The State mails the cards from Raleigh the next work day. EIS generates the SSI Medicaid Straggler Register daily in NCXPTR.
2. Ongoing SSI Medicaid recipients are issued a yearly Medicaid card by EIS. An SSI/Medicaid Regular Run Register is generated in NCXPTR for identification. Regular run is the 11th work night from the end of the month.

V. LIMITATIONS TO MEDICAID ELIGIBILITY FOR SSI RECIPIENTS**A. Refusal to Provide Third Party Resource (TPR) Information**

Providing TPR is not a requirement for SSI, but it is a requirement for all Medicaid programs. When an SSI applicant refuses to provide TPR to SSA, he is advised by SSA that he is not eligible for Medicaid. No action is required by the dss until the recipient contacts the dss.

1. Identification
 - a. Individuals who refuse to provide TPR information are indicated on the SDX by an "R" for the Medicaid Eligibility Code and an "R" for the Third Party Insurance indicator.
 - b. This information is also reported on either the SSI Approval -Medicaid Denial (TPR Refusal) Report (see V.A.2., below) or the TPR Refusal - Medicaid Terminated Report (see V.A.3., below). Refer to EIS 4200 for further information on these reports.

NOTE: Active SAA, SAD, and HSF cases are not terminated. TPR refusal is reported on the TPR REFUSAL-SSI INDIVIDUAL RECEIVING SAA/SAD/HSF Report. This report is for informational purposes.

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(V.A.)

2. SSI Approval/Medicaid Denial (TPR Refusal) Report
 - a. For an SSI approval/Medicaid denial, EIS does not create a Medicaid case or generate a Medicaid card.
 - b. EIS sends an automated Medicaid denial notice. See DMA-5103D, SSI Denial Notice.
3. SSI Approval/Medicaid Terminated Report (except SAA, SAD, or HSF)
 - a. When the individual is in a single person case, the case is terminated.
 - b. When the individual is in a multiple person case, the individual is deleted from the case.
 - c. EIS sends an automated termination notice. See DMA-5103T, SSI Termination Notice.
4. Appeal Rights
 - a. The individual is advised in the denial or termination notice that:
 - (1) He may request an appeal to his county dss within 60 days from the date of the notice if he does not agree with the denial or termination, or
 - (2) He can become eligible for Medicaid by providing TPR information to the local county dss.
 - b. If the individual contacts the county dss and requests an appeal, follow procedures for local hearings in MA-2420, Notice and Hearings Process, for local hearings. Prepare a summary which states: “Social Security has advised the State that you refused to provide medical insurance information.”
 - c. The Medicaid denial or termination can be reversed only when the individual provides his insurance information. This can be done at the appeal or any time the information is provided.
 - d. When the recipient provides the necessary medical insurance information:
 - (1) Use the DMA-5049, Referral to Local Social Security Office, to inform the local SSA office that the recipient has provided the necessary medical insurance information. Request that SSA delete the “R” code from the recipient's record. When the SSA record is updated, this information will be transmitted to the State via the SDX.

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(V.A.4.d.)

- (2) When the SSI Medicaid case is created, complete the [DMA-2041](#), Third Party Health and Accident Resources Information, and enter the insurance information in EIS.

The individual will not receive SSI Medicaid until the corrected information is transmitted to EIS via the SDX. EIS will then automatically create an SSI Medicaid case and issue a notice and card effective the month SSI is effective.

B. Trusts

Certain trusts are not a countable resource in determining SSI eligibility. They may be a countable asset for Medicaid, and therefore affect Medicaid eligibility. When the SDX indicates the individual has a certain trust, EIS will generate a report to DMA.

The DMA Medicaid Eligibility Unit will send notification to the county along with a copy of the EIS report. The county will evaluate the report for effect on eligibility.

VI. SSI DENIAL**A. SSI Denial/Medicaid Denial**

When SSI is denied, SSI Medicaid is automatically denied. EIS sends an automated Notice of Medicaid Denial. See [DMA-5102](#), SSI Denial Notice. There is no notice register for denials.

B. Appeals for Medicaid Denial

When SSA denies SSI and Medicaid, the individual must contact Social Security to appeal the denial of his SSI and Medicaid. The Notice of Medicaid Denial advises the individual to contact SSA to appeal and advises him to contact dss if he wants to be evaluated under another coverage group.

VII. SSI TERMINATIONS

Caseworkers must refer to MA-2320, Recertification, and ensure that all policy requirements are followed for SSI Exparte reviews.

When SSI terminates, evaluate ongoing eligibility for Medicaid in all aid program/categories. The individual remains authorized after SSI is terminated while the evaluation is completed.

When the SSI termination processes in EIS, the termination appears on the SSI TERMINATION REPORT. The SSI indicator changes to "N." The case remains open with a Medicaid through date of 12/31/9999. Within 5 workdays the county dss must initiate an ex parte review to determine whether the recipient qualifies for Medicaid under any other coverage group, including Family and Children's Medicaid which includes pregnant woman coverage, family planning waiver, North Carolina Health Choice for Children, or Work First Family Assistance. For SSI terminations for disability reasons, see D. for ex parte procedures.

(VII.)

A. Automated Recipient Notice

When the SDX indicates a recipient is being terminated from SSI, EIS generates an automated notice to the recipient. See [DMA-5100](#), Notice of Medicaid Redetermination.

The notice advises the recipient:

1. To contact the local SSA if he wants to appeal the SSI termination.
2. The county dss must determine whether he may continue to be eligible for Medicaid as a non-SSI recipient.
3. The county dss will contact him if further information is needed.

When the determination is completed, a timely notice will be sent to inform the recipient of the Medicaid decision.

B. Time Frames for Completing the Evaluation of Ongoing Medicaid Eligibility (Ex Parte Review)

1. Initiate the evaluation of ongoing eligibility within 5 workdays of the date the termination appears on the SSI TERMINATION REPORT. This is essential to ensure enough time to evaluate for ongoing eligibility.

Use the Adult Medicaid Applications or the [DMA-5007](#), MAABD Redetermination Document, as the base document for the evaluation for ongoing eligibility. The SSI recipient's signature is not required for the evaluation, nor can the recipient be required to come into the agency.

Within 4 months of the month the SSI terminated, the county dss must complete the evaluation of ongoing eligibility and notify the recipient about his ongoing eligibility for Medicaid. The four month period begins the month the case appears on the SSI TERMINATION REPORT.

For example, the case appears on the SSI TERMINATION REPORT in July. July, August, September and October are continuation months. Complete the evaluation of eligibility and send the timely notice to make the decision effective no later than October 31.

2. Federal financial participation for up to four months is available for Medicaid during the evaluation. Counties may be liable for charge backs of Medicaid expenditures for ineligible cases if the Medicaid must be extended longer than 4 months to complete an evaluation and/or send timely notice of termination.
3. Recipient Lives In A County Different From That On The SSI TERMINATION REPORT.

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If the recipient lives in another county, the county dss in which the SSI TERMINATION REPORT appears must contact the dss in the county of residence immediately and tell them of the SSI termination. Within 5 workdays the first county must send a copy of the SSI TERMINATION REPORT to the county of residence who must complete the evaluation. Once completed, the first county must be notified so they can key in the results of the evaluation and, if eligibility continues, transfer the case to the county of residence. Cooperation between the two counties is essential to ensure that the evaluation for ongoing coverage is completed timely and there is no break in coverage for the recipient.

C. Medicaid Evaluation for Ongoing Eligibility - Ex Parte Review Procedures

The term “ex parte review” means to review information available to the agency to make a determination of eligibility, without requiring the recipient to come into the agency or make a separate application. The county must explore and exhaust all possible avenues of eligibility in all Medicaid coverage groups. If information is not available to make a determination of eligibility, the county must provide the recipient reasonable opportunity to provide the necessary information. Do not require citizenship/identity documentation during an ex parte review. See [MA-2506](#), US Citizenship Requirements.

1. What Information Must be Reviewed

Review only those eligibility factors that are subject to change, such as income or resources. Do not reverify factors that are not subject to change, such as date of birth or citizenship.

2. Where to Look For Possible Sources of Information

Review all possible sources of information available to the agency, including information verified by other programs. Medicaid eligibility is determined according to the rules of the appropriate Medicaid coverage group. However, the county must accept as accurate verifications from other programs, including:

- a. Information available through automated queries, such as SDX, BENDEX, TPQY, SOLQ, ESC, ACTS and FSIS. (Refer to [MA-2430](#), Automated Inquiry and Match Procedures, and [EIS 1103](#) for instructions on using the SDX, BENDEX, SOLQ and other online inquiries.)
- b. Information collected in the determination of eligibility for other programs, such as Food Stamps, Work First, child care assistance, IV-D child support services and adult or children's services, if the information can be released by the other programs within its rules for confidentiality. For example, child protective services records may not be available.
- c. Information that is current. "Current" means that the information was obtained and verified by the other program within the time frames for redeterminations of eligibility for the Medicaid coverage group being considered, unless there is reason to believe it is inaccurate.

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Current also means that the case is active. Information obtained from a closed or terminated program is not considered current even if verified during the appropriate time frames. A case in suspense is considered active.

For SSI terminations, information on the SDX is no longer current as the SSI case is no longer active. Income, resources and other information subject to change must be verified. The former SSI recipient is exempt from citizenship/identity requirements. Use citizenship/identity code 50, permanently exempt.

For example, if the recipient 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 recipient 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 situations the case in the other program must be currently active.

3. Whose Information to Review

- a. Check all possible sources of information in the SSI recipient's name.
- b. If the names of immediate family members (spouse, parents and stepparents, adult or minor children, and siblings) who live with the recipient are known, check all records in their names. See [DMA-5138](#), Ex Parte Review Checklist (Non-MIC/NCHC Re-Enrollments), for a suggested checklist to document family members.

D. Continuation of MAD When SSI Disability Termination is in Appeal Status - Ex Parte Procedures

When the SSI disability benefit of an active MAD recipient is terminated for no longer being disabled, he or she may continue to be considered disabled while pursuing appeal of the SSI termination. The recipient has only 65 days to request an appeal with Social Security/SSI unless SSA accepts a late appeal for good cause.

1. The case will appear on the SSI Termination Report. Begin the ex parte review process in five work days.
 - a. If the recipient appeals the SSI termination within 65 days or SSA accepts the appeal with good cause and the recipient meets other non-disability criteria for MAD, the ex parte review is complete.

Flag the case and continue to track the SSI appeal according to [MA-2525](#), Disability. Determine if the recipient is receiving Medicare Part B. Contact the Social Security Administration to determine if the recipient will continue receiving Medicare Part B while the SSI termination is being appealed. If necessary, change the classification code from Q or B to N or M when the Medicaid is continued but the recipient no longer receives his Medicare benefit.

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- b. If the recipient does not appeal the SSI termination timely, the recipient is no longer considered disabled and is ineligible for MAD when:
 - (1) He ceases to pursue the SSI appeal up to the appeals council,
 - (2) SSA doesn't accept the appeal for a good cause reason.
2. Begin the process by evaluating eligibility in all coverage groups. Use all agency verifications to determine eligibility before contacting the a/r. Use the [DMA-5180](#), SSI Check Terminated: Information Needed to Determine Medicaid Eligibility, to contact the a/r. If additional information is needed, use the [DMA-5097](#), Request for Information.
 - a. If the recipient remains eligible in another category, immediately transfer the case to that aid program category.
 - b. The county must complete the ex-parte review process in four months. The four months begin the month the case appears on the SSI termination report.
 - c. If the recipient is not eligible in another category, terminate the case after timely notice.
3. If the recipient appeals the county's decision to terminate the case and recipient alleges he is still disabled, request a state hearing. The State Hearing Officer determines if the recipient meets one of the conditions in a., b., or c.
 - a. Has a disabling condition different from, or in addition to the conditions considered in the original SSA disability decision, or
 - b. Alleges more than 12 months after the most recent SSA termination for not being disabled that his condition has changed or deteriorated and his period of disability meets the 12 month durational requirement, and he has not reapplied at SSA based on those new allegations, or
 - c. Alleges less than 12 months after the most recent SSA termination for not being disabled, that his condition has changed or deteriorated, and his period of disability meets the 12 month durational requirement, and
 - (1) He has applied to SSA for reconsideration or reopening and SSA refuses to consider the changes, and /or
 - (2) He does not meet other SSI eligibility requirements e.g., reserve, but may meet the state's Medicaid eligibility requirements for MAD.
4. If the State Hearing Officer determines that a., b., or c. applies, then the State Hearing Officer will determine if the recipient meets the disability requirements. If the Hearing Officer determines the recipient is still disabled, MAD is continued or reinstated.

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A continuing SSA appeal is not a requirement if the hearing officer determines that 3. a., b., or c. applies and that the a/r is disabled.

E. Evaluate All Coverage Groups

Evaluate the recipient's eligibility in all coverage groups. This may involve contacting the recipient to obtain additional information, ONLY if necessary information is unavailable to the agency from another source or is not current. See F.

If the recipient is eligible in more than one coverage group, the recipient has a right to choose the coverage group. Explain the advantages of each coverage group and document the recipient's choice.

1. MAD - Refer to D. for continuation of MAD when SSI disability termination is in appeal status.

If the recipient's SSI was terminated for a non-disability related reason, such as income, evaluate for MAD. If the recipient remains eligible, as MAD, continue MAD. At the next regular eligibility redetermination, submit forms to DDS to establish a regular "Diary/Re-Exam Date" for ongoing reviews of disability.
2. Children Terminated from SSI With Protected Status - Refer to MA-2525, Disability, for instructions for evaluating children with protected status.
3. MAA - If the individual is aged 65 or older, evaluate for MAA.
4. MAB - If the individual has been determined to be blind by Social Security, evaluate for MAB.
5. MAF - Evaluate for MAF-C. If it appears the recipient is eligible for MAF-C, then, advise a/r to apply for Work First. However, approve him for MAF-C if eligible. If the SSI recipient's family is authorized for Work First, the former SSI recipient must be added to the Work First assistance unit.
6. Other Family and Children's Medicaid
 - a. Evaluate the recipient's eligibility in all Family & Children's categories, including MAF, MIC, NCHC, HSF, MPW, Breast and Cervical Cancer Medicaid and Family Planning Waiver.
 - b. If it is known to the agency that the recipient is pregnant, contact the recipient to request verification of pregnancy to evaluate for MPW. If there is no information to indicate pregnancy, continue to evaluate in other coverage groups. It may be necessary to contact the recipient to inquire whether she is pregnant if there is no other basis for eligibility. See instructions in F.

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- c. Medicaid Family Planning Waiver (FPW) – If the recipient is a female age 19 through 55 or a male age 19 through 60, with an income at or below 185% of the federal poverty level, and is not eligible for any other coverage group, evaluate for FPW.
7. North Carolina Health Choice for Children - If the recipient is up to age 19 and is not eligible for Medicaid in any other coverage group, evaluate for North Carolina Health Choice for Children.

F. When and How To Request Information From The Recipient

Information must be requested from the recipient only when it is necessary to determine ongoing eligibility AND the information is not already available to the agency or is not current as described in C.2.

1. Necessary information may be requested by telephone or in writing. If a telephone request is made, advise the recipient what information is needed and that he may request additional time or assistance in obtaining necessary information. Document the record to show the date of the telephone contact, the specific information requested and that the recipient was offered assistance. If the request is in writing, use the DMA-5097, Request for Information.
2. Allow the recipient at least 12 calendar days from the date of the request to provide the information. For example, if a DMA-5097, Request for Information is mailed on January 7 to request current wage information, the deadline for providing the information is January 19.
3. If the recipient does not provide the requested information by the deadline, send timely notice proposing termination for failure to provide the necessary information.
4. Letter to Recipient Prior to Termination

There may be situations in which there is little or no information in the agency regarding an SSI recipient. If you complete the evaluation above and the only potential coverage groups available are in Family & Children's Medicaid, eligibility cannot be established without determining if the recipient is pregnant or has minor children living in the home.

For example, a 34 year old SSI recipient is terminated because she is no longer disabled. She does not receive any other services and is not known to the agency. She could potentially be eligible for MPW if she is pregnant or as an MAF caretaker if she has minor children living with her. If she appeals the SSI termination timely, she can continue to receive MAD.

SSI MEDICAID – AUTOMATED PROCESS

(VII.F.4.)

- a. Send a [DMA-5180](#), SSI Check Terminated: Information Needed to Determine Medicaid Eligibility, to the recipient advising that Medicaid eligibility is being evaluated and additional information is needed. This letter asks if the recipient is pregnant or has minor children living in the home. The letter also explains the Medicaid Family Planning Waiver and asks the recipient if he wishes to apply.
- b. Allow the recipient at least 12 calendar days to return the letter or contact the agency. If the recipient contacts the agency by the deadline, the recipient may request additional time to obtain necessary information such as pregnancy verification.

If the recipient answers yes to either question but provides no other information, contact the recipient to determine if he needs assistance obtaining documentation. Document all efforts to assist the recipient.

- c. If there is no response to the letter by the deadline date, either by phone or in writing or in person, and the recipient is not eligible in any other category, send a timely notice to propose termination.

G. Results of Evaluation for Ongoing Eligibility

1. When all necessary information has been obtained and/or requested, determine whether the recipient is eligible for Medicaid under any aid program/category. One of several eligibility outcomes is possible:
 - a. Recipient is eligible for full Medicaid (MAABD or Family & Children's Medicaid) without a deductible; or
 - b. Recipient will be eligible for full Medicaid (MAABD or Family & Children's Medicaid) if he meets a deductible (Medically Needy), or recipient is eligible as MQB, Q, B, or E, Family Planning Waiver or Breast and Cervical Cancer Medicaid; or
 - c. Recipient is eligible for North Carolina Health Choice for Children; or
 - d. Recipient is ineligible for Work First; or
 - e. Recipient is ineligible for any Medicaid coverage; or
 - f. Recipient did not provide necessary information and coverage must be terminated after timely notice.
2. It is also possible that an additional application may be necessary if the recipient requests assistance for other family members, such as a spouse or children, during the review. Treat the request for additional coverage as a separate application.

(VII.G.)

3. If eligibility is established in any coverage group, the certification period begins with the current processing month in EIS.

Example: Review completed January 27. The current EIS processing month is March. The new certification period begins March 1.

4. If the recipient is eligible as MQB (Q, B or E) only, transfer the case to MQB.

5. Deductible Cases

- a. If the recipient is eligible for Medicaid but must meet a deductible, contact the recipient regarding his predicted or outstanding medical expenses to determine if he can meet the deductible.

He can if:

- (1) His deductible amount is \$300 or less, or
- (2) His predicted expenses or old bills are within \$300 of meeting the deductible.

- b. If it is determined that the recipient can meet his MAABD deductible:

- (1) Certify and put the case in deductible status.
- (2) Follow deductible policy in MA-2360, Medicaid Deductible, to apply medical expenses to the deductible.
- (3) Indicate the deductible amount on the automated notice.

- c. If it is determined that the recipient can meet an MAF deductible:

- (1) Terminate the MAABD case.
- (2) Enter an administrative DSS-8124 to open an MAF case.
- (3) Pend the application to meet the deductible. (MAF cases cannot be approved in EIS in deductible status.)

- d. If it is determined that the recipient's deductible is greater than \$300 or the predicted medical expenses are not within \$300 of meeting the deductible, send timely notice to propose termination.

(VII.G.)

6. MIC or MAF Cases
 - a. Caretakers for SSI children must cooperate with IV-D to establish medical support agreements when the following applies:
 - (1) The caretaker is applying for or receiving Medicaid for herself in any aid/program category except MPW. Refer to MA-2375, Procedures for Child Support Enforcement.

OR
 - (2) The child meets the criteria listed in MA-2375, Procedures for Child Support Enforcement.
 - b. If the recipient is eligible as MIC or MAF, terminate the MAABD case. Enter an administrative DSS-8124 to open an MIC or MAF case.
7. MAF Caretaker Evaluation
 - a. To receive as a caretaker, the individual must be living with and caring for a child under age 19 who is a citizen or alien lawfully admitted for permanent residence (LPR).
 - b. If the county dss knows that the recipient has at least one minor child living in the home for whom care is provided, the caretaker requirement is met.

H. Termination of the MAABD Case

1. Send timely notice to propose termination of Medicaid ONLY IF:
 - a. Information necessary to determine ongoing eligibility is unavailable to agency or is not current, and
 - b. The information was requested from the recipient according to requirements in this section (VII.), and
 - c. The recipient did not respond by the deadlines required in this section,

OR

(VII.H.1.)

- d. All procedures in this section were followed and the recipient does not meet the eligibility requirements for Medicaid in any aid program/category. The assistance may be terminated with timely notice prior to the end of the 4 month period if all ex parte requirements have been met.
2. The recipient may rebut the information stated on the timely notice as the reason for termination within the timely notice period. Always use a termination reason code that most accurately describes the reason for ineligibility.

VIII. SSI OPEN/SHUTS

Sometimes SSI is approved for a finite period in the past. If the individual comes to the dss with an approval letter for a prior period, determine if the individual is on the SSI TERMINATION REPORT.

If the individual is on the SSI TERMINATION REPORT, follow the procedures in VII. If the individual is not on the SSI TERMINATION REPORT, take an application. Follow application procedures in MA-2300 through MA-2304. Refer to EIS 4200 Part Four for instructions for SSI Open/Shut cases.