MEDICALLY NEEDY RECERTIFICATION
03/02/23– CHANGE NO. 04-23

I. BACKGROUND

Federal regulations require that eligibility be evaluated periodically. This section provides recertification procedures for Aged, Blind, and Disabled Adult Medicaid category Medically Needy. Recertifications must be completed so that the appropriate notice can be sent in a timely manner and to ensure that ongoing benefits are issued timely and accurately. When recertification is not completed timely, benefits must be extended one month at a time until the recertification is completed.

II. POLICY PRINCIPLES

A. Definitions

1. **Ex-parte process**: a determination of Medicaid eligibility utilizing information available to the local agency without requesting verification from the beneficiary. This may be electronic sources or information verified by other programs, such as Food and Nutrition Services (FNS) or Work First Family Assistance (WFFA). When information and/or verification must be requested from the beneficiary, the ex-parte process ends.

   When possible, caseworkers should process recertifications using the ex-parte process. See IV., below for more information.

2. **Recertification:** a review of all factors of eligibility subject to change. May be completed ex-parte. For non-MAGI (Modified Adjusted Gross Income) programs, there is no recertification form, and no signature is required to complete a recertification.

3. **Monthly processing deadline**: the second to the last state business day of the month.

B. Reasonable Compatibility

When the recertification cannot be completed ex-parte and the information must be requested via the DHB-5097/DHB-5097sp Request for Information, reasonable compatibility may be applicable. Caseworkers should use the guidance below to determine if reasonable compatibility applies. Refer to MA-2251, Reasonable Compatibility.

1. Reasonable compatibility refers to the standard used to compare the self-attested income/resource and income/resource as reported by an electronic data source.

a. Reasonable compatibility is determined based on the total countable amount of income/resources for the household.

b. Reasonable compatibility cannot be used without a current self-attestation of income/resources.

c. Self-attestation may be the applicant/beneficiary's statement or information they provide. See MA-2251, Reasonable Compatibility.

2. Reasonable compatibility is **not** applicable for income when calculating a deductible for medically needy Medicaid programs or when calculating the patient monthly liability (PML) for long-term care (LTC) and PACE Medicaid programs.

3. Reasonable compatibility **is** applicable for resources for all Medicaid programs that determine eligibility based on resources.

C. Timely Recertification

1. Complete the recertification process for medically needy cases every six months.

2. Begin the ex-parte process no earlier than the beginning of the fourth month of a six-month certification period.

3. The recertification process must be completed prior to the monthly processing deadline of the last month of the certification period.

4. Complete the recertification process in time to allow a timely notice period to expire prior to the monthly processing deadline of the last month of the certification period.

D. Assistance with Recertification

The beneficiary is allowed to have any third person to assist in the recertification process.

E. Reducing or Terminating Benefits

1. Benefits may not be reduced or terminated based on verifications obtained from an electronic source alone. The caseworker must:

a. Update the evidence in NC FAST and

b. Request additional verification from the beneficiary by sending the DHB-5097/DHB-5097sp, Request for Information prior to taking action.

c. Refer to II.B above and MA-2251, Reasonable Compatibility to determine if reasonable compatibility policy is applicable.

2. If the beneficiary fails to respond with the required information requested on the DHB-5097/DHB-5097sp, Request for Information, by the 30th calendar day, terminate the case following timely notice policy found in MA-2420, Notice and Hearings Process.

3. If Medicaid benefits are reduced or terminated, DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance notice must be completed so that it expires prior to the monthly processing deadline to allow for timely notice period. Refer to MA-2420, Notice and Hearings Process.

F. Requesting Information

1. Only request information about individuals living in the home who are financially responsible for those persons receiving or requesting Medicaid coverage.

2. Allow the beneficiary 30 calendar days to respond to the DHB-5097.

3. If the beneficiary does not respond or provide the required information requested on the DHB-5097 by the 30th calendar day, follow notification policy and terminate with timely notice. Refer to MA-2420, Notice and Hearing

G. Self-Attestation

Permit, on a case-by-case basis, self-attestation by beneficiaries of any eligibility requirement except citizenship/immigration status when documentation doesn't exist or is not reasonably available, such as for individuals who are homeless or victims of domestic violence or natural disaster.

H. Evaluate for All Programs

Always evaluate eligibility under all Medicaid categories. This includes all MAGI and non-MAGI Medicaid programs.

I. Eligibility Factors Subject to Change

1. Reverify only those eligibility factors that are subject to change, such as:

- income
- household composition
- resources
- the status of qualified aliens lawfully residing in the United States

- cooperation with child support when applicable, refer to MA-2375, Child Support
- application for all benefits the beneficiary is entitled to

2. If verification is needed at recertification:

   a. Attempt to obtain the verification by conducting an ex-parte review first.

   b. If verification is needed from the beneficiary, send the DHB-5097/DHB-5097sp, Request for Information to the beneficiary and their authorized representative. Allow 30 calendar days for the beneficiary to provide the information.

   c. Refer to MA-2250, Income, and MA-2230, Financial Resources, to determine the correct base-period and countable income/resources.

3. The local agency must obtain the verification for the individual and document in NC FAST when:

   - there is a fee involved in obtaining the information OR
   - if the individual requests assistance OR
   - the individual is mentally, physically, or otherwise incapable of obtaining the information.

J. Providing Assistance

1. When assistance is needed, it must be provided in a manner accessible to persons with disabilities or limited English proficiency.

2. Home visits may be made only at the request of the beneficiary when needed. Home visits may be used to assist the beneficiary in providing information needed to complete the review. Beneficiaries may request a home visit due to incapacity or other good cause.

K. Immigration Status Must be Re-verified at Recertification.

At recertification, the caseworker must review for the beneficiary's immigration documentation. If verification is needed at recertification, attempt to obtain the verification by conducting an ex-parte review before contacting the beneficiary and their authorized representative. If verification is not available ex-parte, request verification using the DHB-5097/DHB-5097sp, Request for Information. Allow 30 calendar days for the information to be provided.

1. Verify the beneficiary continues to reside lawfully in the United States using SAVE, Systematic Alien Verification for Entitlement Program. Refer to NC FAST Job Aid: SAVE Automation Verification. The

caseworker should use any documentation provided at application in the case file.

2. **DO NOT** use SAVE as verification for **trafficking victims**. The case file contains a copy of the Office of Refugee Resettlement (ORR) certification letter received at application. Call the trafficking verification line at (866) 401-5510 to confirm the validity of the certification letter or eligibility letter for children if questionable. See MA-2504, Alien Requirements.

3. If the case (including all agency records and electronic sources) contains an expired document and the beneficiary is unable to present any immigration documentation to verify their immigration status, refer the beneficiary to the local U.S. Citizenship and Immigration Services (USCIS) Office to obtain documentation of their immigration status.

4. If immigration status cannot be verified via the ex-parte process, and the beneficiary has not had a prior reasonable opportunity period (ROP) given:

   a. Request verification by sending DHB-5097/DHB-5097sp, Request for Information, to the beneficiary and their authorized representative.

      Do not ask the beneficiary to mail or leave any original documents at the local agency. A copy of the document is sufficient.

   b. If the beneficiary attests they have a valid immigration status but states they do not have documentation and they are making a good faith effort to obtain the needed documents, document the case.

   c. If all other eligibility requirements are met, complete the recertification and authorize with the appropriate certification period.

5. If ROP was previously applied and documentation confirming immigration status is not provided:

   a. Follow NC FAST Job Aid, Reasonable Opportunity Period, to end-date the verification.

   b. Send a timely DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance notice. Refer to MA-2420, Notice and Hearings.

   c. Terminate the case effective the last day of the current certification period if the beneficiary has received an ROP and failed to provide documentation or did not request assistance in obtaining verification of immigration status.

d. After the ROP has expired the individual must provide documentation confirming immigration status at reapplication.

6. When the beneficiary is a current or former lawful permanent resident (LPR):

a. Refer to MA-2504, Alien Requirements, for acceptable documentation for LPR beneficiaries.

b. Use SAVE to verify the authenticity of the LPR document.

c. Refer to NC FAST Job Aid: SAVE Automation Verification.

L. Eligibility Factors Not Subject to Change

1. Do not reverify factors that are not subject to change, such as:

- date of birth
- citizenship

2. Citizenship and identity documentation is required at application and does not need to be re-established at recertification.

M. Authorized Representative

1. Review all agency records to determine if the beneficiary has one or more of the following:

a. A power of attorney (POA)

b. Legal guardian

c. Authorized representative

d. Refer to MA-2420, Notice and Hearings policy for a complete list.

2. Verify the documentation is not expired.

3. If the documents are expired:

a. Contact the beneficiary by phone or by sending a DHB-5097/DHB-5097sp, Request for Information to determine if the individual on file is still serving in this capacity.

b. If yes, the caseworker should request an updated authorization form.

c. If no response or if the beneficiary indicates the individual is no longer authorized to be their representative, end date the authorized representative evidence.

d. Do not delay the recertification pending authorized representative verification

e. If all eligibility factors are met, recertify the beneficiary into the appropriate program or make program changes as needed.

When the beneficiary does not provide verification that the representative with an expired authorization continues to be authorized, do NOT send the representative any notices or requests for information. Ensure the evidence is end dated.

4. If continued eligibility cannot be determined ex-parte, send all forms and requests for verification to both the beneficiary and the authorized representative.

5. Refer to:

- MA-2420, III. Notice and Hearings for a list of authorized representatives and hierarchy for determining order of priority.
- NC FAST Job Aid: Adding an Authorized Representative.

N. Program Change

1. If the beneficiary is eligible in a different program, obtain necessary verifications and update evidence in NC FAST.

2. When the program the beneficiary is now eligible for is determined using MAGI methodology:

a. Refer to MA-3306, Modified Adjusted Gross Income (MAGI) for eligibility requirements

b. Submit an administrative insurance affordability application in NC FAST. Select “administrative” as the type of application from the drop-down menu.

c. Refer to NC FAST Job Aid: MAGI – Application to Case.

O. Dually Eligible

Beneficiaries who are eligible for both Medicare and Medicaid are dually eligible. When the beneficiary has two product delivery cases (PDCs), the system will generate the appropriate notice for each PDC at recertification.

1. When both PDCs are recertified, the caseworker must not override or cancel either notice.

2. When Medicaid is terminating but the MQB is continuing, the caseworker must not override or cancel either notice. The caseworker must also ensure that the recertification process is completed to allow for the termination notice to be sent timely. Refer to MA-2420, Notice and Hearings Process.

3. When both PDCs are terminating, the caseworker must not override or cancel either notice. The caseworker must also ensure that the recertification process is completed in time to allow for timely notice of termination. Refer to MA-2420, Notice and Hearings Process.

III. INFORMING THE BENEFICIARY OF THEIR RIGHTS AND RESPONSIBILITIES

In-person and telephone interviews can no longer be required at recertification however, the local agency must provide information to the beneficiary which formerly was provided during the recertification interview.

A. Notice of Rights and Responsibilities

NC FAST will generate and mail the DHB-5085, Important Information About Your Rights and Responsibilities for Medicaid at Recertification, on the first day of the tenth month of the beneficiary's certification period.

B. In Person or Telephone Contact

1. When the caseworker has in person or telephone contact with the beneficiary during the recertification process, rights and responsibilities should be explained by the caseworker to the beneficiary.

2. Document on the case that the information on DHB-5085, Important Information About Your Rights and Responsibilities for Medicaid at Recertification, has been explained.

3. At every in person or telephone contact, the caseworker must offer assistance to the individual with creating an ePASS account, and with linking/delinking their ePASS account.

    - The option to **link** their ePASS account is not available to a/bs who DO NOT have a Social Security Number and sufficient credit history.
    - Refer to:

        - Dear County Director Letter (DCDL) posted on May 18, 2022

- The Learning Gateway training, ePASS Linking & Delinking Enhanced Accounts
- NC FAST Job Aid: ePASS Linked Accounts Change of Circumstance

C. Non-Emergency Medical Transportation (NEMT)

Give or mail each beneficiary the DHB-5046, Medical Transportation Assistance Notice of Rights.

D. Third Party Insurance

1. If the beneficiary reports that they have health insurance or have been in an accident, verification of insurance must be provided post eligibility.

2. When an individual is in an accident and Medicaid covers the medical bills when there is third-party liability, inform the beneficiary that if there is an insurance settlement at a later date, Medicaid will recoup up to the amount paid by Medicaid.

   a. Examples of the kinds of insurance that must pay the medical bills or refund the Division of Health Benefits (DHB) are:

      - Health insurance
      - Auto insurance settlements used to pay medical bills
      - Worker's compensation
      - CHAMPUS or Tri-Care
      - Indemnity policies

   b. Explain that:

      (1) By accepting Medicaid, the beneficiary has given the state the right to all money that they might be entitled to from all insurance that will pay for their medical expenses up to the amount paid by Medicaid.

      (2) It is a misdemeanor for anyone to willfully fail to tell the local agency of any claim they may have against anyone for medical expenses, regardless of the kind of insurance or accident involved.

E. Homeless Individuals with No Permanent Address

1. Caseworkers should enter the local agency's mailing address for the homeless beneficiary if they report no other mailing address.

2. Instruct beneficiaries with no mailing address

a. They are responsible for coming to the agency to pick up their annual Medicaid card and necessary notices.

b. They are responsible for checking with the local agency periodically to pick up their mail from the enrollment broker and/or their assigned prepaid health plan (PHP).

3. If the beneficiary fails to pick up their annual Medicaid card for two consecutive months, refer to III.F. below.

F. Returned Mail/Unable to Locate

1. Document all attempts to locate the beneficiary. Documentation must include the date of the attempt and the outcome.

a. Review agency records and other program records for a current address including:

- Food and Nutrition Services (FNS)
- Work First Family Assistance (WFFA)
- Other agency records and/or electronic sources as needed

b. Review current electronic sources for an updated address, such as (not an exhaustive list):

- ACTS
- ESCWS
- SDX
- SOLQ
- TWN

c. Attempt to contact the beneficiary by telephone to obtain a current address.

d. Send a DHB-5097/DHB-5097sp, Request for Information to the most recent mailing address to request verification of a new address.

2. If all attempts to locate the beneficiary are unsuccessful, send an **adequate** DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance to terminate Medicaid. Follow policy in MA-2420, Notice and Hearings Process.

3. If the local agency **is able to locate** the beneficiary prior to the end of the current certification period, reopen the terminated case from the first day of the month after the month of termination and authorize benefits through the end of the certification period.

Example:

- Caseworker begins ex-parte recertification on 10/5 for a beneficiary's case with a certification period that ends 12/31.
- The caseworker discovers that additional information is required and mails the beneficiary a DHB-5097 on 10/10.
- The caseworker receives returned mail on 10/28 with no forwarding address for the beneficiary.
- The caseworker then follows the policy in steps one and two above. After exhausting all efforts to locate the beneficiary on 11/15, the caseworker terminates the case using the reason "unable to locate" effective 11/30 and mails adequate notice to the beneficiary.
- On 12/15, the beneficiary contacts the caseworker after a medical provider informs them that their Medicaid is not active.
- The beneficiary provides a new address, and the caseworker reopens the case, authorizing benefits through 12/31 (the original certification end date).
- Because the caseworker originally was unable to complete the recertification ex-parte, the new certification period cannot be authorized until the recertification is completed.
- The caseworker must follow the steps in four, below.

4. At recertification, when the original returned mail item is the DHB-5097/DHB-5097sp, Request for Information, mailed by the caseworker to request verification to complete the recertification, take the following steps when the local agency **is able to locate** the beneficiary prior to the end of the **current** certification period:

   a. Generate and mail another DHB-5097/DHB-5097sp, Request for Information, requesting the same information that is needed to complete the recertification.

   b. Allow the beneficiary **30 calendar days** to provide the information.

   c. If the 30th calendar day is in the month after the certification period ends, extend the certification period for one month at a time until the recertification process is complete.

   d. If the beneficiary fails to respond or is no longer eligible, and there is not enough time to mail timely notification after the 30th calendar day, extend the certification period for one month at a time until the timely notification process is complete.

Example:

- Using the same scenario in the example under III.F.3. above, the caseworker reopened the case and generated and mailed the DHB-

5097 requesting the same information required to complete the recertification.

- The beneficiary returns the information, however, the information provided results in ineligibility for all Medicaid programs.
- The caseworker determined the beneficiary is ineligible on 12/21 and generates and mails timely notice which expires in January.
- Because timely notice does not expire before the end of the current certification period (12/31), the caseworker extends the benefits for one month, with the end date of 1/31.

IV. EX-PARTE RECERTIFICATION

A. Ex-parte

1. All recertifications must be completed using electronic data sources, and available agency records to determine continued eligibility prior to contacting the beneficiary/authorized representative.

2. When using available agency records, the information must be:

   a. Verified information.

   b. From an active case or pending application.

   c. Within the current base period for the recertification.

3. Electronic data sources and agency records include but are not limited to:

   a. Online Verification Service (OVS)

   b. The Work Number (TWN) - (can only be completed inside of NC FAST due to contractual requirements)

   c. Food and Nutrition Services (FNS)

   d. Work First Family Assistance (WFFA)

   e. Other agency records and/or electronic sources as needed

B. Base-Period and Countable Income/Resources

Refer to policy sections below to determine the correct base-period and countable income/resources:

1. MA-2250, Income

2. MA-2230, Financial Resources

V. WHEN CONTINUED ELIGIBILITY CANNOT BE DETERMINED EX-PARTE

When continued eligibility cannot be determined or eligibility will change to a lesser benefit, continue in deductible status, or terminate, the caseworker should follow the steps below. After completing these steps, the caseworker must recertify, reduce, or terminate the case after allowing appropriate notice.

The caseworker is required to provide notification to the beneficiary of the source and amount of income used to determine the six-month deductible amount, and the medically needy certification period via the DHB-5097/DHB-5097sp, Request for Information.

When information must be requested from the a/b, the ex-parte process ends. Refer to II.A. above.

A. Request Information

1. Send the DHB-5097/DHB-5097sp, Request for Information, to the beneficiary and the authorized representative.

    a. Request all required information, including both paid and unpaid medical bills, and anticipated medical expenses to meet a new six-month deductible. Accept the beneficiary's statement of anticipated medical expenses if their statement reasonably shows that the deductible may be met by anticipated medical expenses (e.g., scheduled surgery).

    b. When requesting medical bills to meet a deductible, the caseworker **must** include the new/changed deductible amount on the DHB-5097/DHB-5097sp.

    c. The DHB-5097/DHB-5097sp must include the amount and source of the income used to calculate the deductible, and the new six-month medically needy Medicaid certification period.

    d. Allow **30 calendar days** to provide requested information.

    e. If the beneficiary **does not respond** to the DHB-5097/DHB-5097sp, however the local agency **has old medical expenses** in the case file that are sufficient to meet or come within $300 of meeting the new six-month deductible, the caseworker should recertify the medically needy PDC.

    f. If the beneficiary **responds and reports** anticipated medical expenses within the new certification period, authorize the medically needy PDC. The PDC cannot be activated until the six-month deductible is met.

g. If the beneficiary **does not** respond to the DHB-5097/DHB-5097sp and there are **not** enough medical bills in the case file sufficient to meet or come within $300 of meeting the new six-month deductible, and there is no indication of anticipated medical needs, the caseworker should terminate the medically needy PDC with timely notice and evaluate for all other Medicaid programs.

h. If the beneficiary **does respond** to the DHB-5097/DHB-5097sp but does not have old, current, or anticipated medical expenses sufficient to meet or come within $300 of meeting the new six-month deductible, the caseworker should terminate the medically needy PDC with timely notice and evaluate for all other Medicaid programs.

2. The local agency must obtain the verification for the individual and document in NC FAST when:

a. There is a fee involved in obtaining the information OR

b. The individual requests assistance OR

c. The individual is mentally, physically, or otherwise incapable of obtaining the information.

B. Examples

1. Local agency has existing medical bills provided by the beneficiary at application or last recertification to meet a new six-month deductible:

a. Provide the beneficiary with notification of the new six-month deductible amount, the medically needy certification period, and the income source and amount used to calculate the deductible amount. Provide this notification via the DHB-5097/DHB-5097sp.

b. When the beneficiary has previously provided medical bills that will meet a new deductible, the caseworker must verify with the medical provider the amount the beneficiary is currently responsible for.

c. When remaining medical bills have been verified and the six-month deductible for the next certification period is met with these bills, the caseworker should complete the ex-parte recertification and recertify the case in NC FAST if all other factors of eligibility have been met.

d. The caseworker must send a timely DSS-8110 notice to the beneficiary that includes the amount of the deductible.

2. Local agency does not have existing medical bills that can be used to meet a new six-month deductible:

a. The ex-parte process ends when it is discovered that the caseworker cannot determine ongoing eligibility using electronic sources and available information.

b. The caseworker must follow the procedures in V.A., above to request information including medical bills to meet the six-month deductible. The DHB-5097/DHB-5097sp must also include the amount and source of income used to calculate the deductible.

c. If the beneficiary does not respond or responds that they have no old, current, or anticipated medical bills to meet the deductible by the 30th calendar day, the caseworker must evaluate for all other Medicaid programs, including family planning, and authorize if eligibility factors are met.

d. DSS-8110 timely notification is required if the case will terminate or if eligibility will continue with a lessor benefit.

3. Deductible status:

a. If the beneficiary provides medical bills that are within $300 of the six-month deductible, or if the beneficiary reports an anticipated medical expense that will meet or come within $300 of the six-month deductible, the case may be approved in deductible status.

b. Refer to VI.B. below for recertifying in deductible status.

c. Timely DSS-8110 notification is required. The notice must include the amount of the new deductible.

C. Using Collateral Contacts

Collateral contacts are used to substantiate or verify information necessary to establish eligibility.

1. Collateral contacts include specific individuals, business organizations, public records, and documentary evidence. Specific alternative collateral contacts that may be used for verification are outlined in the eligibility determination sections.

2. For more information about allowable contacts, refer to the policy section related to the evidence type being verified, i.e., if verifying income, review the appropriate policy section for income.

3. Collateral contacts should only be used if the recertification cannot be completed ex-parte.

4. Limit collateral contacts to those necessary to obtain the required valid information and where the beneficiary requests assistance or cannot obtain the needed verification.

5. If the beneficiary/representative does not want the local agency to contact necessary collateral contacts, ask them to obtain the information themselves.

6. If the beneficiary does not cooperate in providing/obtaining the necessary verifications, terminate the case following timely notice requirement. Refer to MA-2420, Notice and Hearings.

7. Update/add verification on the evidence dashboard of the income support case in NC FAST. See the following NC FAST Job Aids:

   a. Managing Spend Down Evidence

   b. Income & Expense Evidence Wizards – Income Support

   c. Adding Evidence to Cases

   d. Verifications

   e. NC FAST Mandatory Evidence and Verifications

D. Wage Verification

When wage verification is needed:

1. The DSS-8113, Wage Verification Form, may be sent to the employer when it is known that the information is not available to the local agency.

2. The form should be sent at the same time the DHB-5097/DHB-5097sp is sent to the beneficiary and authorized representative.

E. Modes for Providing Requested Information

Inform the beneficiary that requested information may be provided by:

1. Telephone

2. Mail

3. In-person

4. Electronic/fax

5. ePASS (for beneficiaries with a linked account)

F. When All Requested Information/Verification is Received:

1. Complete the recertification, or

2. If **additional** information is identified, send a second DHB-5097/DHB-5097sp, Request for Information, and allow the beneficiary 12 calendar days to return the information.

VI. RECERTIFICATION PROCEDURES

A complete recertification of all eligibility factors subject to change is required once every six months for Medically Needy cases. Refer to MA-2120, Medically Needy Regulations.

A. Policy Procedures

1. Always evaluate for all Medicaid programs. This includes all MAGI and non-MAGI Medicaid programs.

2. Begin working recertifications for medically needy cases no earlier than the fourth month of the six-month certification period. Refer to NC FAST Job Aid: Traditional Medicaid Recertifications, for instructions for beginning and working recertifications in NC FAST.

3. There cannot be a lapse in coverage during the Medicaid recertification process.

4. Local agency staff must utilize the Traditional Medicaid Pending Recertification Details reports to ensure that all cases due for recertification by the end of the month are completed or extended (refer to VI.F. below).

B. Recertify in Deductible Status:

If the beneficiary was able to meet the current six-month deductible but is not able to meet the deductible in the next certification period, the case may be authorized in deductible status. The case cannot be activated in NC FAST until the deductible is met.

1. Recertify medically needy cases into deductible status for a consecutive six-month certification period if all eligibility requirements continue to be met, and the deductible

    a. Was met in the previous certification period, or

b. Is expected to be met in the next certification period. A recertification must be conducted to determine if the deductible is expected to be met in the next certification period.

2. If a case is authorized for meeting the deductible in the previous certification and the case has a deductible in the new certification period, send the beneficiary and their authorized representative a DHB-5097/DHB-5097sp, Request for Information. Refer to V.A. above for specific information that must be included on the DHB-5097/DHB-5097sp when requesting medical bills to meet a deductible.

   a. If the beneficiary is ineligible for any other Medicaid program, send a timely DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance to terminate the case.

   b. Refer to MA-2420, Notice and Hearings Process for timely notification policy.

3. When the beneficiary is authorized but not approved in deductible status and is also eligible for Medicaid for Family Planning (FPP),

   a. Refer to II.N. above for steps for processing an administrative application to authorize FPP.

   b. Refer to MA-2170, Family Planning Program for policy requirements.

C. Program Change

When the beneficiary becomes eligible for MQB-B/E at recertification:

1. If the beneficiary is eligible for another Medicaid program that does not provide full Medicaid coverage (i.e., Family Planning, MQB), send a timely DSS-8110: Notice of Modification, Termination, or Continuation of Public Assistance for a program change.

2. MQB-B eligible

   a. If the beneficiary is eligible for MQB-B and the deductible was met during the current certification period:

      (1) Recertify the medically needy Medicaid product delivery case (PDC).

      (2) Accept the changed decision to authorize the medically needy PDC in deductible status and generate the appropriate DSS-8110: Notice of Modification, Termination, or Continuation of Public Assistance which includes the new six-month deductible amount.

(3) Authorize and activate the MQB-B PDC from the eligibility check.

(4) Mail DHB-5002/DHB-5002sp, Important Notice About Your Medicaid or Special assistance Approval Notice to notify the beneficiary of the new program approval.

Refer to NC FAST Job Aid: Traditional Medicaid Recertification for keying instructions to activate the new PDC.

b. If the beneficiary was not able to meet the six-month deductible in the current certification period and is now eligible for MQB-B:

(1) Close the medically needy Medicaid PDC.

(2) Accept the changed decision to generate the appropriate timely DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance notice.

(3) Authorize and activate the MQB-B PDC from the eligibility check

(4) Mail DHB-5002/DHB-5002sp, Important Notice About Your Medicaid or Special Assistance Approval Notice to notify the beneficiary of the new program approval.

Refer to NC FAST Job Aid: Traditional Medicaid Recertification for keying instructions to activate the new PDC.

3. MQB-E eligible

a. MQB-E beneficiaries cannot be dually eligible.

b. When the beneficiary met their current deductible but has not provided medical bills to meet a new six-month deductible, contact the beneficiary. Document that the following is explained to the beneficiary:

(1) The beneficiary may choose to remain in deductible status if they anticipate meeting a new six-month deductible.

(a) During the six-month deductible status certification period, the beneficiary's Medicare premium will continue to be paid by Medicaid.

(b) The medically needy Medicaid case will be approved beginning the date that the six-month deductible is met and will continue through the remainder of the certification period.

(c) If the six-month deductible is not met during the certification period, the medically needy Medicaid case will terminate at the end of the six-month deductible status certification period.

(d) The beneficiary will be required to reapply for Medicaid and be evaluated for all programs, including MQB-E.

(2) The beneficiary may choose to terminate the medically needy Medicaid case and remain eligible for MQB-E.

(a) The beneficiary's Medicare premium will continue to be paid by Medicaid for the remainder of the current calendar year.

(b) The beneficiary's MQB-E case will be reviewed and recertified if eligible for the next calendar year if the beneficiary remains eligible for MQB-E and federal funding is approved for the MQB-E program.

c. If the beneficiary meets the new six-month deductible to remain eligible for medically needy Medicaid or chooses to remain in deductible status (anticipates meeting the six-month deductible), MQB-E should not be authorized. Follow the steps in VI.C.4. below to terminate the medically needy PDC and authorize the MQB-E PDC.

4. If the beneficiary is determined eligible for a MAGI Medicaid program:

a. Accept the changed decision on the current medically needy Medicaid case to generate the applicable timely or adequate notice, based on ongoing eligibility.

(1) If eligibility is changing from medically needy to categorically needy in a greater benefit program, mail adequate notice.

(2) If eligibility is changing from medically needy to categorically needy in a lesser benefit program (i.e., FPP), mail timely notice.

b. Refer to NC FAST job aid, MAGI – Application to Case to key a new application.

c. When keying the new application, choose "Administrative Application" from the application type drop-down menu.

d. After authorizing and activating the new PDC, generate and mail a DHB-5003, Medicaid or NC Health Choice Approval Notice.

D. Terminating with Timely Notice

1. If the case is ineligible in any other Medicaid program, the previous deductible was not met, and there is no indication that the deductible can be met in the next certification period, mail a timely DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance.

2. Prior to termination, always evaluate each individual in the case in all other Medicaid programs for ongoing benefits.

3. Refer to NC FAST Job Aid: Traditional Medicaid Recertifications and follow the steps to close the case in NC FAST.

4. The caseworker must complete the steps in NC FAST at least ten state business days prior to the end of the certification period.

5. Timely notice should be generated in NC FAST. Refer to the following for policy and system requirements:

   a. MA-2420 Notice and Hearings Process

   b. NC FAST Job Aid: MA/MAGI DSS-8110 Notice of Modification, Termination, or Continuation of Assistance

E. Requirements: Appeal Requests

1. An a/b has the right to appeal an action if they disagree with the local agency decision.

2. An appeal may be requested verbally or in writing in any of the following modes of communication:

   a. Via the ePASS portal

   b. Telephonically

   Note: When the beneficiary contacts the local agency and leaves a voice message requesting to appeal an action to be taken by the local

agency, the caseworker must attempt to contact the beneficiary by telephone no later than the following business day.

The caseworker must document the call in NC FAST and include:

- Date and time of the original voice message.
- Date and time of the returned call.
- Telephone number(s) used to attempt to contact the beneficiary.
- Outcome of the call (successful, unsuccessful, left message, etc.)
- Details of the call relevant to the case and appeal request.

c. In-person

d. Via all electronic data sources (i.e., fax, email, etc.)

e. In writing

Refer to MA-2420, Notice and Hearings Process, for complete policy.

F. Untimely Completion of Recertifications – Franklin v. Kinsley Requirements

Franklin v. Kinsley (5:17-CV-581 E.D.N.C.) – previously known as Hawkins v. Cohen, is a federal lawsuit filed in 2017 on behalf of Medicaid beneficiaries in North Carolina. The Court has ordered N.C. Department of Health and Human Services (DHHS) and all 100 county Department of Social Services (DSS) to stop terminations or reductions of Medicaid benefits until eligibility under all Medicaid categories, including Medicaid for the Disabled (MAD), has been considered and proper notice of the termination has been sent.

It is imperative that caseworkers begin working recertifications in a timely manner. The procedures below apply if the caseworker does not complete the process timely OR if the beneficiary submits information late in the recertification process that must be verified.

When the recertification cannot be completed so that timely notification can be completed by the end of the current certification period:

1. Active benefits must continue on a month-by-month basis until timely notification procedures have been followed.

   a. The local agency must comply with the Franklin v. Kinsley court order by ensuring that caseworkers extend medically needy benefits for the next month utilizing forced eligibility by following NC FAST Job Aid: Forced Eligibility for Income Support Medical Assistance, Special Assistance, & Cash Assistance.

b. In order to comply with Franklin v. Kinsley, if the recertification is not completed and no extension is given by the local agency, NC FAST will automatically extend the benefits for one month at a time until the recertification is completed.

c. If the local agency fails to fully comply with the Franklin v. Kinsley court order and NC FAST automatically extends benefits, the local agency will be financially responsible for any erroneous benefits and Medicaid claims payments if the beneficiary is determined ineligible. This is required by the court order and N.C. Gen. Stat. § 108A-25.1A.

2. If the beneficiary is in deductible status with no active benefits, the extension process above does not apply. Refer to VI.B., above for more information on deductible status.

3. Timely notice should be generated in NC FAST. Refer to the following for policy and system requirements:

a. MA-2420, Notice and Hearings Process

b. NC FAST Job Aid: MA/MAGI DSS-8110 Notice of Modification, Termination, or Continuation of Assistance

VII. MANAGED CARE ENROLLMENT

A. Enrollment in Prepaid Health Plan

1. Medically Needy beneficiaries are **excluded** from enrolling in a Managed Care Prepaid Health Plan (PHP).

2. Refer to NC FAST Job Aid: MC/TO – Managed Care Status Reference Guide for information regarding mandatory, exempt, and excluded statuses.

B. Medicaid Direct: Community Care of North Carolina/ Carolina Access (CCNC/CA) Enrollment

1. Individuals who are exempt from enrollment with a PHP may choose to enroll with a PHP or they may choose to be Medicaid Direct. If Medicaid Direct is chosen, enroll the a/b in CCNC/CA.

2. Individuals excluded from enrollment with a PHP remain Medicaid Direct and CCNC/CA policy applies.

3. The local agency must enroll excluded individuals or exempt beneficiaries who choose Medicaid Direct in CCNC/CA:

a. At application

b. Recertification

c. Any time a beneficiary contacts the agency to request a change in CCNC/CA enrollment status.

4. Refer to MA-2425, Community Care of North Carolina (CCNC)/Carolina Access (CA)

C. Program Changes that Impact Managed Care or Medicaid Direct

1. When a beneficiary was enrolled in Managed Care and is now Medicaid Direct, caseworker action is not required unless the beneficiary reports a change to their primary care provider (PCP). When the beneficiary reports a change to their PCP, the caseworker must update the evidence in NC FAST.

2. When a beneficiary has moved from a NC Medicaid Direct program to a Managed Care program, no caseworker action is required. NC FAST will make necessary changes to the beneficiary's managed care status.

VIII. WHEN TO REOPEN CASE TERMINATED FOR MISSING INFORMATION

A. Information Received by the 90th Day Following Termination

1. A case which terminates for not cooperating with the recertification process or for failure to provide information must be reopened if **all** information necessary to approve eligibility is received by the 90th of the month following termination.

2. Determine eligibility as if the information was received timely, from the first day of the month following the termination date.

B. Information Not Received by the 90th Day Following Termination

Do not reopen the case if **all** required information is not received prior to the 90th of the month following termination. Notify the beneficiary that a new application for Medicaid is required.