

CHANGE NOTICE FOR MANUAL NO. 08-03, Application Processing, MA-3215, Processing the Application

DATE: AUGUST 12, 2002

Manual: Family and Children's Medicaid MA-3215

Change No: 08-03

To: County Directors of Social Services

Effective: October 1, 2002

I. BACKGROUND

On February 5, 2002, Judge Graham C. Mullen, Chief Judge, U.S. District Court for the Western District of North Carolina, dismissed the Alexander Consent Order. The February 1992 version of the Consent Order required payment of penalties or remedial fines if the counties did not process applications according to federal regulations and State rules.

Judge Mullen approved a "Plan to Assure Timely and Quality Services to Applicants for Medicaid, otherwise known as the Exit Plan". The Centers for Medicare and Medicaid Services and Legal Services had approved this Exit Plan. The State had worked with a group of county representatives in developing this plan.

The persons from the following counties who worked on this plan were:

Brenda Davis of Catawba County

Millie Brown and Elva Quinn of Duplin County

Dave Bradshaw and Dale Moorefield of Forsyth County

Betty Barnes of Johnston County

Jean Biggs and Vicki Lewis of Martin County

Sarah Bradshaw and Alvinia Parker of Sampson County

Although the Exit Plan does not change all that the counties wanted, it did result in the dismissal of the Consent Order. The Exit Plan reflects the commitment of both the State and the counties to continue to provide accurate benefits to our citizens in a timely manner. Each county in the State deserves recognition for its efforts. It is critical that counties continue to provide accurate benefits in a timely manner.

Work First (WF) applications are not under the Exit Plan. However, a Work First application is considered an application for Medicaid. If a person comes to the agency to ask for financial assistance, he must be given the opportunity to apply for Medicaid that same day. This applies even if the county requires the person to go to the Employment Security Commission or to the Child Support Enforcement office before taking a WF application.

Due to changes needed in the Eligibility Information System, all aspects of the Exit Plan could not be implemented until EIS was ready. In DMA Administrative Letter No. 19-02, some policy changes were made without EIS support. These included:

- A. The requirement to pend applications for three months ended.**
- B. Penalty checks are no longer issued.**
- C. DDS is no longer required to pend applications.**
- D. The requirement to complete an interview unless the client arrives at the agency within 30 minutes of closing changed to 60 minutes.**
- E. The requirement to send out two requests for information with 10 calendar days between requests changed to sending out two requests for information with 12 calendar days between requests. (The 10-10 rule became the 12-12 rule.)**

As a result of enhancement to EIS, all of the aspects of the Exit Plan can now be implemented.

II. CONTENT OF CHANGE

MA-3215, Application Processing, Processing Situations, has been rewritten and renamed MA-3215, Processing The Application.

- A. This section contains procedures for processing an application and all possible outcomes. All applications for Family and Children's Medicaid aid/program categories must be processed within 45 calendar days.**
- B. An application must be approved, denied or withdrawn on the 45th day unless:**
 - 1. It is pending solely for medical bills to meet the deductible, or
 - 2. It is pending for applicant or third party responsible verification and the 12-12 rule has not been met.

In these situations, the application must pend beyond the application due date to allow the applicant or third party the full 12 days to provide the missing information. If the verification is not provided, the application may be denied on the 13th day following the second request for information.

C. Applications pending solely for medical bills to meet the deductible when the anticipated medical expenses are within \$300.00 of meeting the deductible may be held pending for up to 6 months.

1. Applicants requesting long term care that are not placed in a Medicaid certified medical facility by the application due date must be denied unless otherwise eligible PLA.
2. Awaiting long term care placement is no longer considered an anticipated medical expense to meet the deductible. Do not pend the application for six months unless the applicant has other anticipated medical expenses that indicate the deductible may be met.

D. Under certain circumstances, days may be excluded from processing time when the county DSS is waiting for the following information and this is the only information needed to process the application:

1. Medical bills to meet the deductible,
2. Disability determination
3. Receipt of medical records to determine emergency dates for non-qualified aliens,
4. FL2/MR2,
5. CAP Plan of care.

E. Dispositions

1. Withdrawals
 - a. This change in policy obsoletes the DSS-8191W. The DSS-8109, Your Application For Benefits is Being Denied or Withdrawn, is now used to notify the individual that his application has been withdrawn. Due to enhancements to EIS, an automated notice of withdrawal can be sent for all aid program/categories.
 - b. When a request for withdrawal is received by mail or by leaving a message, the IMC must make at least one attempt to contact the individual by phone to discuss the alternatives to withdrawing the application and must document the attempt to contact the individual. If contact is made, the IMC must document the discussion and results.
2. Denials

An application may be denied on the 45th day for failure to provide information unless:

- a. It is pending solely for medical bills to meet the deductible and anticipated medical expenses are within \$300.00 of meeting the deductible, or
- b. It is pending solely for a disability determination, or
- c. It is pending for applicant or third party responsible verification and the 12-12 rule has not been met.

If 12 days have not passed since the second request for information, hold the application pending for the full 12 days following the second request for information, even if it pends beyond the 45th day.

3. Open/Shut Approvals

When an individual is found eligible for a portion of a certification period, authorize assistance open/shut for the period of time the individual was eligible.

When a medically needy applicant requests ongoing Medicaid, the six-month deductible must be met prior to authorization regardless of the number of months in the ongoing certification period unless there is a change in income or the individual dies.

- a. **Example #1** A medically needy non-qualified alien has a medical emergency during the month of application. Emergency medical dates are approved by DMA. The individual must meet the ongoing six-month deductible before the emergency medical dates can be authorized.

In this situation, the IMC should fully explain to the individual the option of applying for retroactive assistance including the reserve and residence requirements during the retroactive period.

- b. **Example #2** A medically needy individual requests withdrawal of his application because he has moved to another state to live with his son. The individual reports that he moved to the other state upon discharge from the hospital.

The individual also reports that he has enough medical bills to meet the original six-month deductible. The certification period is January through June. Medical bills indicate that the six-month deductible was met on March 9th. The individual moved to the other state on March 16th.

Approve the application open/shut for March 9th through March 31st. Do not recompute the deductible. The ongoing six-month deductible must be met even if the certification period is three months.

4. Reopened Approvals, Denials, Withdrawals, and Inquiries

- a. A reopened application refers to an application that was originally denied or withdrawn but the denial or withdrawal was incorrect, improper, or

reversed. It can also refer to an application or inquiry when there is evidence of discouragement.

- b. Applications reopened due to local/state appeal reversals or remanded appeals, must be processed within 5 workdays of receipt of the last piece of required information.
- c. Applications reopened due to improper denials/withdrawals, incorrect denials, or discouragement, must be held open for up to 45 days or until 13 days after the second request for missing information, whichever occurs later. However, if it is pending solely for a disability determination and/or medical bills to meet the deductible, the application may be held open for up to 6 months.

To determine if the application has pended the 45 days, subtract the number of days the original application pended from 45. The difference is the number of days the reopened application must pend to meet the 45 day requirement. Do not include any days the application was closed.

For example, a MAF application dated June 10th was improperly denied on June 25th. The original application pended a total of 15 days. On August 30th, an administrative DSS-8125 was entered to reopen the application. The reopened application must pend for at least 30 calendar days (September 29th) or until 13 calendar days after the second request for information, whichever is later.

- (1) If the anticipated medical expenses are within \$300.00 of meeting the deductible continue to pend the application for up to 6 months.

To determine if the application has pended 6 months, subtract the number of days the original application pended from 180. The difference is the number of days the reopened application must pend to meet the 6 month requirement. Do not include any days the application was closed.

For example, a MAF application dated June 10th was improperly denied on June 25th. The original application pended a total of 15 days. On August 30th, an administrative DSS-8125 was entered to reopen the application. A review of the case record indicates that anticipated medical expenses are within \$300.00 of meeting the deductible and this is the only information needed to complete the application. The reopened application must pend for at least 165 days (February 11th) or until 13 calendar days after the second request for information, whichever is later.

- (2) If the anticipated medical expenses are not within \$300.00 of meeting the deductible, deny the application.

III. EFFECTIVE DATE

This policy change is effective October 1, 2002.

IV. IMPLEMENTATION PROCEDURES

Apply these changes to any applications taken on or after October 1, 2002. For applications dated prior to October 1, 2002, follow the policies and procedures in effect prior to October 1st. This means that for an application taken prior to October 1, 2002, days can only be excluded from the application processing time while waiting for bills to meet the deductible.

V. MAINTENANCE OF MANUAL

Remove: MA-3215, Application Processing, Processing Situations.

Insert: MA-3215, Processing The Application.

Online Manual: Entire Section Revised with hyperlinks to forms.

Remove: MA-5000, Figures and Instructions for the following forms:

A. DSS-8109, Notice Of Denial Of Public Assistance.

B. DSS-8191W, Notice of Withdrawal.

Insert: Nothing to insert.

Online Manual: These forms have been added to the policy section.

If you have any questions regarding this material, please contact your Medicaid Program Representative.

Nina Yeager
Director

(This policy was researched and written by Vanessa Broadhurst, Policy Consultant, Medicaid Eligibility Unit.)

[MA-3215](#)

[MA-3215, Fig. 1, DSS-8109](#)