MEDICALLY NEEDY RECERTIFICATION

REVISED 11/16/23– CHANGE NO. 16-23

Current Change Notice: 16-23

- II: a definition has been added for 90-day reopen.
- III.C: updated information regarding automatic mailing of the DHB-5046.
- II.E: a subsection has been added which provides clarification for reducing or terminating Medicaid benefits at a critical age review or at the end of the 12-month postpartum period.
- V: multiple updates to caseworker guidance regarding requesting information at recertification.
- VII.B: policy reference added. This subsection is being temporarily removed from policy while updates are completed.
- VII.E: language has been updated to be consistent with language found in other policy sections regarding Medicaid recertifications.

I. BACKGROUND

Federal regulations require that eligibility be evaluated periodically. This section provides recertification procedures for non-MAGI (Modified Adjusted Gross Income) Family & Children's Medicaid medically needy program. 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. Refer to 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 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.

4. **90-Day reopen:** 90-day reopen policy applies when required information is received within 90 days from the termination effective date.

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-3310, Reasonable Compatibility.

1. Reasonable compatibility refers to the standard used to compare the self-attested income/resources and income/resources 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-3310, 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 Benefits or Terminating – Franklin Requirements for Critical Age or End of the 12-Month Postpartum Period

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.

1. Beneficiaries whose benefits will be potentially reduced or terminated at recertification or as a result of critical age change or end of postpartum will receive DHB-2187, Notice of Potential Change in Medicaid Eligibility.

2. Refer to VI. for instructions regarding requirements for individuals who allege disability. Benefits may not be reduced or terminated if the a/b meets the requirements in VI.

F. 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

   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-3310, 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, terminate the case following timely notice policy found in MA-3430, Notice and Hearings Process.

3. If Medicaid benefits are reduced or terminated, a 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-3430, Notice and Hearings Process.

G. Requesting Information

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

H. 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.

I. Evaluate for All Programs

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

J. 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

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.

   c. Refer to MA-3300, Income, and MA-3320, 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.

K. 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.

L. Immigration Status Must be Re-verified at Recertification

At recertification, the caseworker must review 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.

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. Refer to MA-3330, 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 evidencing 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, apply ROP, and 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. See MA-3430, Notice and Hearings.

c. Terminate the case effective the last day of the current certification period if the beneficiary has received a 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-3330, 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.

M. 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.

N. 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-3430, Notice and Hearings Process policy for a complete list.

2. Verify the documentation is not expired.

3. If the documents are expired, contact the beneficiary to determine if the individual on file is still serving in this capacity. If yes, the caseworker should request an updated authorization form.

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-3430, 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

O. Program Change

1. If the beneficiary is eligible in a different Medicaid 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.

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

3. When the beneficiary states they are disabled, turns age 65, or becomes eligible for Medicare, refer to the Medicaid for the Aged, Blind, and Disabled policy manual for eligibility requirements.

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)

The DHB-5046, Medical Transportation Assistance Notice of Rights is generated and mailed by NC FAST when the recertification is marked complete in NC FAST.

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 III.G. below.

F. Child Support Referral

1. Cooperation with child support is required. See MA-3365, Child Support, to determine if a referral is required.

2. When required, the caseworker should inform the beneficiary they must cooperate with child support enforcement.

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

   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:

   a. Ensure that all requirements regarding the DHB-2187, Notice of Potential Change in Medicaid Eligibility, are followed. Refer to VIII.A. below.

b. Medicaid benefits may not be terminated until 60 calendar days after the date the DHB-2187 was mailed.

c. The caseworker must review the DHB-2187 in NC FAST to determine the date mailed. Then use the Time Standards chart to calculate the 60th calendar day.

d. Send an **adequate** DSS-8110 to terminate Medicaid effective the last day of the month in which the 61st day falls. Follow policy in MA-3430, 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 and ensuring that 60 calendar days have passed since the DHB-2187 was mailed, 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. Electronic data sources and agency records include but are not limited to:

a. Online Verification Service (OVS)

b. 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. Child Support

During the ex-parte recertification process:

1. Review the NC Automated Collection and Tracking System (ACTS) via OVS.

2. If ACTS indicates non-cooperation for the parent/caretaker, the caseworker should propose termination and mail a timely DSS-8110: Notice of Modification, Termination, or Continuation of Public Assistance.

3. Refer to MA-3430, Notice and Hearings Process for policy regarding timely notification.

C. Base-Period and Countable Income/Resources

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

1. MA-3300, Income

2. MA-3320, Resources

V. WHEN CONTINUED ELIGIBILITY CANNOT BE DETERMINED EX-PARTE

Information in this section is being updated. Please refer to MA-3421 for complete, updated information regarding requirements for requesting information and what steps to take when information is or is not returned.

When continued eligibility cannot be determined or eligibility will change to a lesser benefit, continue in deductible status, or terminate based on the ex-parte review, the caseworker should follow the steps below. After completing these steps, the caseworker must recertify 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.

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 it 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.

When the date due is a non-business day, allow the beneficiary until the next business day to provide the requested information.

e. If the beneficiary **responds and reports** anticipated medical expenses within the new certification period, determine if the deductible will be met on the **first day** of the new certification period.

(1) If the deductible will be met on the first day of the new certification period, complete the recertification and authorize medically needy Medicaid.

(2) If the deductible will NOT be met on the first day of the new certification period, evaluate for all other MAGI and non-MAGI Medicaid programs, including MXP. Authorize if eligible.

(3) If ineligible for any other full Medicaid program, authorize the medically needy PDC. The PDC cannot be activated until the six-month deductible is met.

f. 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 the new six-month deductible on the first day of the new certification period, 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, including MAGI Adult Group (MXP).

g. If the beneficiary **does respond** to the DHB-5097/DHB-5097sp but does not have old, current, or anticipated medical expenses sufficient

to meet the new six-month deductible on the first day of the new certification period, the caseworker should terminate the medically needy PDC with timely notice and evaluate for all other Medicaid programs, including MAGI Adult Group (MXP).

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

Examples will be updated and added to this section at a later date.

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, see 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. See MA-3430, 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 (if applicable)

    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 <u>All</u> 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. FRANKLIN REQUIREMENTS AT RECERTIFICATION

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.

A. Franklin Requirements: Beneficiary Alleging Disability

Beneficiaries receiving full Medicaid in any Family and Children's program, including MPW, and who allege disability may be eligible to have their benefits continued while a disability determination is made. At recertification, caseworkers must review and follow the guidance in this section.

This protection applies to Medically Needy cases **only** if the a/b meets their deductible prior to the end of the certification period.

1. DHB-2187, Notice of Potential Change in Medicaid Eligibility

   This form notifies the beneficiary of the right to allege disability and how to have their current benefits continued while disability is being determined.

   a. All beneficiaries receiving **full** Medicaid benefits in any Family and Children's program must receive the DHB-2187, Notice of Potential Change in Medicaid Eligibility, 180 calendar days prior to the end of their certification period for categorically needy beneficiaries.

   b. The requirement to receive the DHB-2187 does not include beneficiaries eligible for limited eligibility programs, i.e., Family Planning Medicaid.

   c. For all medically needy cases, NC FAST generates the DHB-2187, Notice of Potential Change in Medicaid Eligibility when the caseworker activates the Medically Needy PDC.

   d. NC FAST will maintain an electronic copy of the notice.

      If the DHB-2187 is **NOT** present on the case for the individual beneficiary do **NOT** terminate the case. The benefits must be continued until the DHB-2187 is mailed and the 60 calendar days have expired. The caseworker **MUST** submit an NCFAST Helpdesk ticket.

   e. A medically needy beneficiary's benefits may not be reduced or terminated any earlier than 60 calendar days after the date the DHB-2187 was mailed.

      (1) When the beneficiary's certification period is scheduled to end prior to the 60th calendar day from the date of the DHB-2187, the caseworker must extend the case, utilizing continued eligibility.

(2) The case must be extended through the last calendar day of the month in which the 60th day falls.

Example: DHB-2187 was generated and mailed on June 15, when the beneficiary met the deductible. The 60th day from June 15, is August 14. The caseworker must extend benefits through August 31.

(3) If the beneficiary fails to contact the local agency within 30 calendar days to allege disability or apply for MAD, benefits are not protected beyond the end of the month in which the 60th calendar day falls.

Example: DHB-2187 generated and mailed June 15. The beneficiary contacts the local agency on August 1. This is beyond the first 30-day period and therefore, benefits are not protected beyond August 31 (the end of the month in which the 60th day falls).

(4) If the beneficiary does contact the local agency within the first 30-day period and alleges disability but fails to submit an application for MAD within 30 calendar days after contacting the local agency, benefits are not protected beyond the end of the month in which the 60th calendar day falls.

Example: DHB-2187 is generated and mailed June 15. The beneficiary returns the DHB-2187 by mail. The DHB-2187 indicates that the beneficiary alleges disability and is received on July 1. The caseworker is unable to contact the beneficiary by telephone and mails the beneficiary an application on July 5. The beneficiary did not submit an application for MAD by any method (mail, in-person, electronic, or telephone) on or before the 30th day after alleging disability. Benefits are not protected beyond August 31 (the end of the month in which the 60th day falls).

2. Medicaid may terminate no earlier than 60 calendar days after the DHB-2187 has been mailed to the beneficiary unless:

   a. The beneficiary has moved out of state.

   b. The beneficiary is deceased.

   c. The beneficiary voluntarily requests termination of Medicaid.

(1) The request must be in writing and specifically request Medicaid termination.

(2) Maintain the written request with the case in NC FAST. The record must include documentation that the individual understood that they and/or their children may still be eligible for Medicaid and chose not to continue.

3. When the beneficiary reports alleged disability, the caseworker must:

a. Review the date of the DHB-2187 in NC FAST.

Beneficiaries who receive the DHB-2187 have 30 calendar days from the date the notice was mailed to contact the local agency and **allege** disability for any member of the Medicaid case.

b. Document that the beneficiary has contacted the local agency to allege disability. Beneficiaries may allege disability in the following ways:

(1) Completing and returning the DHB-2187 to the local agency electronically, by mail, or in person.

(2) Visiting the local agency in person to allege disability.

(3) Calling or emailing the local agency to allege disability.

(4) Submitting an application for Medicaid for the Disabled (MAD).

c. Document in the NC FAST case file the following:

(1) The date that the beneficiary contacts the local agency to allege disability **and**

(2) The date that the local agency provides instructions to the beneficiary regarding how to submit an application for MAD. Refer to VI.A.4. and 5. below.

The beneficiary has 30 calendar days from the date the local agency provided instructions to the beneficiary to **submit** an application for MAD.

4. The local agency must explain that the individual must submit an application for MAD and offer to assist the beneficiary alleging disability with submitting an application for MAD.

a. For in person or telephone interactions, the caseworker should offer to take the application at the time of contact.

(1) If the beneficiary does not have time to complete the application for MAD on the same day, an appointment should be scheduled to complete the interview.

(2) The appointment may be scheduled for an in person or telephone interview, according to the beneficiary's preference.

(3) The date of application is the date of the telephone interview or the date the individual requests to be evaluated for Medicaid and an appointment is made.

b. When the beneficiary contacts the local agency electronically or in writing, the caseworker must mail a paper application with instructions for submitting the application.

5. At recertification, including critical age review and end of postpartum review, caseworkers must take the following steps for the beneficiary alleging disability only (does not apply for other members of the Medicaid case who are not alleging disability):

a. At recertification, review the case to determine if the beneficiary contacted the local agency to allege disability within 30 calendar days from the date of the DHB-2187.

(1) If the beneficiary did **not** contact the local agency within the 30-calendar day period, continue with the recertification. The beneficiary is not eligible to have their current benefits continued while awaiting a disability determination. However, the caseworker must ensure that 60 calendar days have passed since the DHB-2187 was mailed, prior to reducing or terminating the current benefits. The individual must be given the full 60 days to allege disability and/or apply for MAD.

(2) If the beneficiary **did** make contact with the local agency within the 30-calendar day period, the caseworker should take the following steps:

(a) Determine the date the beneficiary made contact to allege disability.

(b) Determine the date the beneficiary was provided with instructions for submitting an application for MAD.

(c) Review NC FAST to determine if an MAD application has been submitted for the beneficiary alleging disability.

(d) Determine the date the MAD application was submitted.

(e) If the MAD application was **submitted** within 30 calendar days from the date the local agency has provided instruction to the beneficiary regarding how to submit an application for MAD, the beneficiary must continue to receive full Medicaid benefits in a Family & Children's Medicaid program until disability is determined and the beneficiary has had an opportunity to appeal that decision. The caseworker must continue the case utilizing medical forced eligibility.

Refer to NC FAST job aid: Forced Eligibility for Income Support Medical Assistance, Special Assistance, & Cash Assistance.

(f) If the MAD application was submitted **more than 30 calendar days** after the date the local agency provided instructions to the beneficiary regarding how to submit an application for MAD, continue with the recertification.

The beneficiary is **not** eligible to have their current MAGI benefits continued while awaiting a disability determination. However, the benefits may not be reduced or terminated earlier than 60 calendar days after the day the DHB-2187 was mailed.

b. If an MAD application was submitted within the timeframe in VI.A.3. above, current benefits **cannot be changed, reduced, or terminated** until a disability decision is made and the beneficiary has had an opportunity to appeal that decision.

(1) For parent/caretakers whose youngest child has reached age 18, the parent/caretaker's case should be extended in MAFC.

(2) For beneficiaries receiving MPW, at the end of the 12-month postpartum period, the benefits must be extended in MPW.

B. Franklin Requirements: Appeal Requests

The Franklin court order requires that beneficiaries who have applied for and been denied Medicaid based on disability (MAD) have the right to a hearing on whether they are disabled before their Medicaid under a Family & Children's category is reduced or terminated. It is very important that the following procedures be followed before adverse action is taken for individuals who applied for MAD. The instructions below are in two parts.

- The first part is designed to protect beneficiaries who have already requested an appeal of the MAD application denial.
- The second part is designed to protect those beneficiaries whose MAD application has been denied and the deadline to appeal that denial has not yet expired.

If an MAD application was submitted within the timeframe in VI.A.3. above, current **Family & Children's Medicaid** benefits cannot be changed, reduced, or terminated until a disability decision is made and the beneficiary has had an opportunity to appeal that decision. Take the steps **in VI.B.2 below** prior to taking adverse action to reduce or terminate Medicaid when the MAD application was filed within the above time frames and has since been denied:

1. Appeals process reminders:

   a. When a beneficiary requests an appeal, the caseworker should review MA-3430, Hearings and Appeals Process. An a/b has the right to appeal an action if they disagree with the local agency decision.

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

      (1) Via the ePASS portal

      (2) 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.

(3) In-person

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

(5) In writing

c. Anytime the beneficiary requests a hearing to appeal a decision, explain to the beneficiary policy regarding the right to continued benefits found in MA-3430, Notice and Hearing Process, section V.B.8.

2. MAD application denial – appeal status

The following steps should be taken **only if** the beneficiary submitted an MAD application within the timeframes specified above in VI.A. above **and** the MAD application has since been denied:

a. Determine if the beneficiary has requested an appeal of the MAD application denial.

b. MAD application denial has been appealed:

(1) Continue the current Family & Children's Medicaid benefits until the state hearing officer has made a decision on the MAD appeal.

Refer to NC FAST Job Aid: Continued Eligibility for Medical Assistance for keying instructions.

(2) If the state hearing officer rules that the beneficiary is disabled, the Family & Children's Medicaid PDC should be terminated, and the MAD application reopened and approved.

(3) If the state hearing officer rules that the beneficiary is not disabled, follow the guidance in VII.C. and VII.D. below to reduce or terminate the beneficiary's Family & Children's Medicaid benefits with timely notice.

c. MAD application denial **has not been appealed**:

(1) Follow guidance in VII.C. and VII.D. below to reduce or terminate the beneficiary's Family & Children's Medicaid benefits with timely notice.

(2) If the beneficiary appeals the decision on the **Family & Children's Medicaid** termination or benefit reduction notice within **10 state business days,** follow instructions in VII.B.3. below.

(3) If the beneficiary **does not** contact the local agency to appeal the Family & Children's Medicaid termination or reduction within **10 state business days,** do not continue Family & Children's Medicaid benefits.

3. MAD application denial – appeal deadline

When the MAD application denial has not been appealed, and guidance in VII.B.2. above has been followed, determine if the 60-day deadline to request a hearing to appeal the MAD application denial has passed.

a. When the deadline to appeal the MAD application denial **has passed**, but the deadline to appeal the Family & Children's Medicaid termination or benefit reduction has not passed:

(1) Schedule a local hearing that does not consider the issue of disability (based on the Family & Children's Medicaid case reduction or termination).

(2) If the beneficiary meets the requirements to continue to receive Medicaid during the appeals process and elects to do so, continue current Family & Children's Medicaid benefits until a decision is made by the local hearing officer.

Refer to NC FAST Job Aid: Continued Eligibility for Medical Assistance for keying instructions.

b. When the deadline to appeal the MAD application denial **has not passed**, and the beneficiary contacts the local agency to request an appeal for the reduction/termination of the Family & Children's Medicaid, the caseworker must ask if they continue to allege disability.

(1) If the beneficiary states that they no longer allege disability, schedule a local hearing that does not consider the issue of disability (based on the Family & Children's Medicaid case reduction or termination).

(2) If the beneficiary states that they do continue to allege disability:

(a) Schedule a state hearing to appeal the MAD application denial.

(b) Reinstate or continue the current Family & Children's Medicaid benefits until the state hearing officer has made a decision on the MAD appeal.

(c) Refer to VII.B.2.b. for guidance when the state hearing officer has made a decision.

VII. 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-3315, Medicaid Deductible.

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 report to ensure that all cases due for recertification by the end of the month are completed or extended (see VII.E. below).

B. Recertify in Deductible Status:

Information in this subsection is being updated. Refer to V.A., above and MA-3421.

C. Program Change

1. If the beneficiary is eligible for another Medicaid program that does not provide full Medicaid coverage (i.e., Family Planning), send a timely DSS-8110 for a program change.

2. 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. See 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 product delivery case (PDC), generate and mail a DHB-5003, Medicaid 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.

   If ineligible for any Medicaid program, take the following steps:

   a. Ensure that all requirements regarding the DHB-2187, Notice of Potential Change in Medicaid Eligibility, are followed. Refer to VIII.A. below.

   b. Medicaid benefits may not be terminated until 60 calendar days after the date the DHB-2187 was mailed.

   c. The caseworker must review the DHB-2187 in NC FAST to determine the date mailed. Then use the Time Standards chart to calculate the 60th calendar day.

d. Send an **adequate** DSS-8110 to terminate Medicaid effective the last day of the month in which the 61st day falls. Follow policy in MA-3430, Notice and Hearings Process.

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-3430 Notice and Hearings Process

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

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

Franklin v. Kinsley (5:17-CV-581 E.D.N.C.) 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 (10th month of 12-month certification period or 4th month of 6-month certification period). 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. The caseworker must continue extending benefits 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 Medicaid benefits for the next month. Ensure that the beneficiary's benefits continue for the same program being recertified.

      - For cases that can be extended utilizing "Medical Continued" evidence, refer to NC FAST Job Aid: Continued Eligibility for Medical Assistance.

- For cases that must be extended by utilizing forced eligibility, refer to 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 VII.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-3430 Notice and Hearings Process

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

VIII. 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-3435, 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.

IX. 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 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 following termination.