2.4 MEDICAID

Individuals who receive Medicaid experience the same kinds of changes between application and redetermination and between redeterminations as individuals who receive Food Stamps and WV WORKS. The differences are as follows:

- For Medicaid, there is no benefit level determined. Therefore, the individual is either eligible or ineligible. Every reported change results in a redetermination of eligibility.

- For most Medicaid coverage groups, eligibility of family members is determined on an individual basis. Therefore, the same change could impact each family member differently.

- Regardless of any changes, except those specified in Section 2.8, a child determined eligible for a child's Medicaid coverage group must have 12 QC or PL months of continuous coverage. See Section 2.8.

See Chapter 17 for case maintenance requirements for nursing care services, ICF/MR, HCB Waiver or MR/DD.

The Worker has no case maintenance requirements for illegal aliens emergency coverage or QDWI.

Specific items other than the eligibility determination are addressed here.

A. SOURCES OF INFORMATION

In addition to the sources listed in Section 2.1, the information found in Section 2.3 may also be used for Medicaid.

DUE TO THE DELETION OF POLICY, THERE IS NO LONGER A PAGE 34.

B. REPORTING REQUIREMENTS

All changes in the client's circumstances such as, but not limited to, income, assets, household composition and change of address must be reported.

Changes are reported as soon as possible after the client becomes aware of them. This allows the agency to make a change and allows for advance notice, if the reported information results in an adverse action.

C. AGENCY TIME LIMITS

The Worker must take action on reported changes as soon as possible. When the Worker is aware of anticipated changes which may effect eligibility, a control is set to take action at the appropriate time.

D. TYPES OF CHANGES

1. Change In Case Name

The case name may be changed from one individual to another at the request of the individuals involved or when a change in circumstances requires it.

A new application must be completed and signed by the new payee unless his signature is on the most recent application.

If the client's name changes, no new application is necessary.

For QMB, SLIMB, QI-1 or QI-2 a new application must be signed by the spouse, if he becomes eligible, even though he will be added to the existing case.

2. Change Of Address

A change of address is made in the data system as soon as the client reports it. Any other changes which the client reports, in addition to the address change, are also acted on at the same time when notice requirements permit. A change made prior to the deadline date is effective the following month.

When the address change is made after the deadline date, the change is effective 2 months after the change is made. See item E,3 below for instructions for returned medical cards.

3. Change In The Assistance Group, Needs Group Or Income Group

When there is an addition to or a deletion from the AG and/or Needs Group, individual eligibility for each member must be reevaluated. See Chapter 9. This change(s) may require data system action.

For special requirements relating to CEN'S, see Section 2.1,C.

When there is an addition to or deletion from the Income Group or a change in the income of the existing group, financial eligibility must be reevaluated. See Chapter 10.

EXCEPTION: Changes in income do not effect the eligibility of Poverty-Level and Deemed Poverty-Level pregnant women. Also, regardless of any changes, except those specified in Section 2.8, a child determined eligible for Medicaid must have 12 months of continuous QC or PL coverage. See Section 2.8.

NOTE: For QMB, SLIMB, QI-1 and QI-2 the RSDI COLA's are disregarded in determining income eligibility through March of the year they become effective.

4. Assistance Group Closures

When the recipient's circumstances change to the point that he becomes ineligible, the case is closed. There are instances in which a Medicaid AG is closed by the data system.

EXCEPTION: Changes in income do not effect the eligibility of Poverty-Level and Deemed Poverty-Level pregnant women. Also, regardless of any changes, except those specified in Section 2.8, a child determined eligible for Medicaid must have 12 months of continuous QC or FPL coverage. See Section 2.8.

EXCEPTION: Changes in income do not effect the eligibility of Poverty-Level and Deemed Poverty-Level pregnant women.

NOTE: For QMB and SLIMB, the RSDI COLA's are disregarded in determining income eligibility through March of the year they become effective.

5. Case Closures

When the recipient’s circumstances change to the point that he becomes ineligible, the case is closed. There are instances in which Medicaid cases are closed by the data system. This occurs when:

- TM coverage expires

- Medically Needy non-spenddown cases that are not redetermined in the sixth month of the POC, and

- Medically Needy spenddown cases are closed at the end of the POC, regardless of whether spenddown was met or not.

In no instance is Medicaid Coverage under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. This is done before the client is notified that his Medicaid eligibility will end. Eligibility is determined based on case record information. The client may be required to visit the office only for completion of a Social Summary for a MRT referral.

See Section 2.11,D for special procedures for SSI Medicaid when an individual is determined no longer disabled by SSA.

E. CORRECTIVE PROCEDURES

1. Reimbursement For Out-of-Pocket Expenses

When determining if the client is eligible to receive direct reimbursement for out-of-pocket medical expenses which would have otherwise been paid by Medicaid, but for the error or delay of the Department, it is the responsibility of the Department to act on each application or case action correctly within a reasonable period of time, unless the delay is due to factors beyond the control of the Department. A reasonable period of time must be interpreted on a case-by-case basis.

In addition, if an application has been erroneously denied, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses paid by the client which would otherwise been paid by Medicaid, but for the error of the Agency.

Reimbursement for out-of-pocket medical expenses is limited to reimbursement for those services covered by Medicaid. The client is reimbursed for the entire sum of his out-of-pocket expenses for those covered services even if that expenditure exceeds the Medicaid fee schedule in effect at the time the expenditure was incurred.

Direct reimbursement may be made for purchases of drugs during the time before submission of the request, if the purchases were made following:

- The failure of the Department to act on the application within a reasonable period of time and the delay is not due to factors beyond the control of the Department; or

- The erroneous denial of the application for Medicaid.

The CSM is responsible for determining if the client is eligible to receive reimbursement for out-of-pocket medical expenses. If it is determined that the client is eligible to receive reimbursement, the CSM must submit a memorandum to the IM Policy Unit in OFS requesting reimbursement, along with the original invoices for the medical expenses for which reimbursement is requested. The memorandum must contain the amount of the reimbursement that is due the client and the accompanying bills must be marked or highlighted to indicate if they are used for reimbursement.

2. Holding the Medicaid Card

Medicaid cards of TANF recipients may be held only when the case is eligible for School Clothing Allowance only, and is approved after the August deadline. Other Medicaid cards may not be held under any circumstances.

3. Procedures Relating to Incorrect Or Returned Medicaid Cards

Upon receipt of these cards, the State Office mails them to the appropriate county office. Medicaid cards for TANF recipients on the monthly payroll are part of the mailing package which includes the TANF check and are returned to Accounts Receivable. When a client reports that information on his Medicaid card is incorrect, he may take it to the county office for correction.

When the address is incorrect, the Worker remails the card or gives it to the client when he learns the correct address. Medical cards for TANF clients on the monthly payroll are released with the check using the ES-14. The transmission to correct the address must be done before deadline.

b. Incorrect Cards

When a client reports that information on his Medicaid card is incorrect, he may take it to the county office for correction.

c. Card Not System-Issued

When Medicaid eligibility is established in RAPIDS, but a card is not system-issued, the Worker must complete a manual card, RAPIDS verification letter or manual verification letter, whichever is appropriate, and mail or give to the client. Under no circumstance must a manual card or verification letter be issued unless eligibility dates are established in RAPIDS. See instructions in Section 21.4,B for completion of a manual card or verification letter.

4. Incorrect Eligibility Dates

When an incorrect eligibility period(s) is reflected in RAPIDS, the Worker must follow the appropriate RAPIDS procedure or Work-Around to correct the date(s).

When a client who has a spenddown, submits bills and meets the spenddown, later sends in additional bills which would have met the spenddown at an earlier date, the Worker must follow the appropriate RAPIDS procedure or Work-Around to correct the eligibility date and insure that the client receives a correct card or verification letter for the new eligibility period. The POC remains the same.

The Worker must send a corrected IM-MS-1 to BMS. RAPIDS generates form EDA7 to the client to inform him of his correct date of eligibility.