16.3 MEDICAID ELIGIBILITY BETWEEN COVERAGE GROUPS

The Worker must consider all of the following information in determining eligibility and in establishing eligible cases.

A. CONSIDERATION OF ALL MEDICAID COVERAGE GROUPS

The client cannot be expected to know which Medicaid coverage group to apply for. When the client expresses an interest in applying for Medicaid, the Worker MUST EXPLORE ELIGIBILITY FOR ALL MEDICAID COVERAGE GROUPS. This does not mean that applications for all coverage groups must be taken and processed. It means that Medicaid eligibility cannot be denied until the client has been considered for each coverage group and that, if the client is eligible under more than one coverage group, he is approved for the one that will provide him with the most benefits in the fastest time frame.

Even if the client does not request an eligibility determination for Medicaid, the Worker must explain its availability if he believes the family could benefit from it.

IN NO INSTANCE IS MEDICAID COVERAGE UNDER ONE COVERAGE GROUP TO BE STOPPED WITHOUT CONSIDERATION OF MEDICAID ELIGIBILITY UNDER ALL 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 MRT.

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

B. WHO RECEIVES LIMITED COVERAGE

All Medicaid coverage groups receive the full services the State offers to its Medicaid recipients except the following coverage groups: QMB, SLIMB, Illegal Aliens, AIDS Programs, QDWI. The limitations are described in Sections 16.5 - 16.11 In addition, any coverage group's services can be limited when a penalty for an uncompensated transfer of resources is applied. Refer to Chapter 17 to determine when to apply such a penalty and to the RAPIDS User Guide to accomplish the limitation.

C. BACKDATING MEDICAID COVERAGE

Unless specifically stated under the appropriate coverage group, Medicaid coverage may be backdated for up to three months prior to the month of application, provided all eligibility requirements were met at that time and provided the client has unpaid medical expenses.