1.24 PROCEDURES IN THE MEDICAID APPLICATION PROCESS

A. SPOUSES APPLY - ONE APPROVED, ONE PENDING

When an application is made for a couple and one spouse is eligible, but the application for the other remains pending because disability has not been established, the procedure is as follows:

- Approve the application for the eligible spouse. Deeming procedures in Chapter 10 apply.

- Send an approval notice to the eligible individual and include an explanation that eligibility for the spouse has not been established and the reason.

If the spouse is determined eligible at a later date, the procedures depend upon whether or not the previously ineligible spouse has income, whether or not such income was deemed to the recipient and whether or not there is a spenddown.

When the income of the previously ineligible spouse equals $0, or has been deemed to the recipient spouse, or does not cause the AG to have a spenddown, the following procedures apply.

- Take data system action to add the spouse to the AG. The beginning POC or POE for the spouse is the same as for the recipient;

- Send an approval notice to the recipient to inform him that eligibility for the spouse has been established and the date on which his medical coverage begins.

- If the individual is added after the deadline date in the 6th month of the POC, proper RAPIDS procedures must be followed to insure issuance of a medical card.

When the previously ineligible spouse has income, but it was not deemed to the recipient spouse, and it causes the AG to have a spenddown, the following procedures apply.

If the eligible spouse did not previously have a spenddown, but the addition of the previously ineligible spouse and his income makes the AG subject to spenddown, the following actions are taken:

- The previously ineligible spouse is added to the AG; and

- The AG is closed after proper notice and is reopened with a new POC. The new POC must not cover any period of time in which the AG was in a POE; and

- The AG must be supplied with proper notice about the spenddown and the procedures which now apply.

If the eligible spouse had a spenddown which was met and is currently in an active AG, the following actions are taken:

- Add the previously ineligible spouse to the AG for the current POC. The AG is not closed prior to the end of the current POC due to increased countable income.

- When the AG reapplies for a new POC, all income is counted and appropriate spenddown procedures apply.

If the spouse is determined ineligible, the Worker sends the recipient a denial notice.

Appropriate **e**RAPIDS Screens must be updated and a recording made in **e**RAPIDS case comments about the denial.

B. DEATH OF THE ONLY INDIVIDUAL PRIOR TO APPLICATION OR APPROVAL

Death of an individual does not interfere with approval of a Medicaid application. However, special procedures are required when the only member of a Medicaid AG dies prior to making an application. If an application is made prior to an individual's death, the application is processed as usual and approved, if eligible. This item outlines the special procedures that the Worker must follow in the application process and at approval.

1. Who Must Be Interviewed And Sign The Application

An interview is not required but when an interview is conducted, the interview requirements in Section 1.2 are applicable.

Another individual makes the application on behalf of the deceased person. It is preferable that the person be a relative, but any other individual who is interested may make the application on behalf of the deceased person.

The Worker must obtain as much information as possible about the deceased person’s income and assets, but routine verification is not required.

2. MRT Referral

It is not necessary to refer the case to MRT when the deceased person's incapacity or disability resulted in his death. However, a MRT referral may be necessary to establish incapacity, blindness or disability when there is a request for Medicaid coverage for a month(s) prior to the person's death and such incapacity, blindness or disability was not the cause of death, or the Worker is unable to determine if the incapacity, blindness or disability existed during the month(s).

All other policies and procedures related to incapacity or disability coverage groups apply.

C. DOCUMENTATION AND REVIEW OF PENDING MEDICAID APPLICATIONS

To document the reason for any delay in processing a Medicaid application, the Worker must record in comments:

- All actions taken in processing the application.

- The results of required case reviews.

The instructions for these procedures are found below. A rebuttable presumption that the application was not acted on within a reasonable period of time exists when conditions such as, but not limited to, are met:

- Proper documentation, as shown below, which establishes that delay is due exclusively to factors beyond the control of the Department, is not in the case record;

- Documentation for the required case review is not in the case record.

This presumption may be rebutted only by clear and convincing evidence that all necessary actions by the Department for processing the application were undertaken in a timely fashion. This presumption may not be rebutted solely by the testimony of a Worker who failed to meet the documentation requirements.

1. Instructions For Documentation For Pending Medicaid Applications

Action on each application must be noted in comments and by coding the appropriate **e**RAPIDS Screens.

EXAMPLE:

Date	Recording	Worker	Data Transmission
10/10/95	Client applied. All elig. req. met except spdwn. DFA-6 and 6A given for medical bills	Jones	N/A See case comments of 10/10/95
11/6/95	Medical bills received ($432). Not enough to meet spenddown.	Jones	N/A
11/8/95	More bills received ($617). Spdwn met approval notice sent	Jones	

For all Medicaid applications, the documentation on comments and/or the appropriate **e**RAPIDS Screens must include, but is not limited to, the following:

- Date of application.
- Date the verification checklist or DFA-6 and 6A were mailed or given to the client.
- Date medical bills submitted by the client were received in the local office.
- Date medical expenses were added to RAPIDS.
- The result of each 30-day review found on comments (instructions in item 2 below).
- All actions related to the MRT process, when applicable, which include, but are not limited to:
  - Date initial medical reports are requested
  - Date of follow-up activity required to obtain initial reports
  - Date medical reports are received in the county office

- Date additional medical information, as indicated on the initial medical report or as requested by MRT, is requested
- Date of follow-up activity required to obtain the additional medical information
- Date additional medical reports are received in the county office
- Date material is referred to MRT
- Date the Worker is notified of the final MRT decision

This information appears in **e**RAPIDS.

2. Procedure For Review Of Pending Applications

Applications that have not been entered in the data system must be reviewed at least each 30 days.

The county office must establish procedures to ensure that each pending application is reviewed a minimum of once every 30 days. The results of the review must be documented in the case record. Comments must document the reason the application has not been acted on. If this reason is not beyond the control of the Department, the Worker must immediately take any actions are necessary to process the application. If the application has not been acted on within the required time limit, the Worker must send an DFA-20 or RAPIDS notice NMRL to the applicant informing him of the information which has not been received by the Department. The DFA-20 or NMRL is sent to the client at the time of the expiration of the maximum allowable time for acting on the application.

D. DETERMINING REASONABLE PERIOD OF TIME FOR SPENDDOWN ENTRY

Cases that meet spenddown should be entered in the data system in the 30 day application period.

E. PRIOR ELIGIBILITY FOR CASES NOT CURRENTLY ELIGIBLE

When it is established that eligibility requirements for prior Medicaid coverage were met, but the case is not currently eligible, the procedures are as follows:

3. Approvals

The application is approved for Medicaid to cover the prior period. The medical card is mailed to the local office and is rewritten for the correct POE and mailed to the client. For a spenddown case, verified medical expenses, old unpaid bills prior to the POC, or paid and unpaid bills incurred during the POC, are used as spenddown expenses.

A manually written medical card for the correct POE is mailed to the client.

4. Denials

When the Worker determines that the case does not meet spenddown in the prior period, the application is denied and the client notified using the DFA-NL-A.

5. Closures

Advance notice requirements apply. When the 13-day advance notice of closure is not required, the procedure is as follows:

If a card will be generated, it must be sent to the address of the county office. The Worker must ensure the client receives the closure notice.

A closure is transmitted immediately following the approval or spenddown transaction.

When the card is received in the county office, the Worker must destroy it and manually issue a medical card to reflect the prior POE. The Supervisor initials the card and either mails it or gives it to the client. It is the client's responsibility, or that of the individual who is acting on his behalf, to take the card to medical providers.

F. CHANGING COVERAGE GROUPS AND REDETERMINATION PERIOD

When one coverage group is closed and another opened, the AG may be assigned a new certification period.

G. COORDINATION BETWEEN THE DEPARTMENT AND THE FEDERALLY-FACILITATED MARKETPLACE (FFM)

The Affordable Care Act established standards and guidelines for ensuring a coordinated and timely process for performing eligibility determinations, for facilitating enrollment into coverage and for transferring the client’s information between the Department and the Marketplace.

The Department must enter into an agreement with the Marketplace which outlines the responsibilities of each program to ensure prompt determination of eligibility and enrollment in the appropriate insurance affordability program based on the date the application is submitted to either the Department or the Marketplace.

Regardless of where the client submits their SLA, eligibility can be determined based on the information collected on the application without requiring additional action by the client.

1. Applications Taken by the Marketplace

West Virginia entered into an agreement with the FFM whereby the Department will accept as final the Medicaid and WV CHIP eligibility determinations made by the Marketplace based on MAGI.

When completing the eligibility determination for a client that submits an application to the Marketplace, the Marketplace must:

- Accept the SLA,
- Check for existing Medicaid or WV CHIP coverage,
- Verify citizenship/immigration status, residency, incarceration status, current monthly income and annual income,
- Apply the reasonable compatibility standard and reconcile any differences,
- Apply West Virginia's state eligibility rules,
- Conduct any additional verifications that may be required,
- Complete the eligibility determination,
- Provide appropriate notices and communications to the client, and
- Transfer applications to the Department for client's requesting a full determination of Medicaid on a basis other than MAGI.

a. When the Marketplace determines the client is eligible for a MAGI coverage group

The Department must:

- Promptly complete enrollment into the correct Medicaid or WV CHIP coverage group.
- Not request any additional information or verifications from the client.
- Provide additional notification of enrollment to the client, including benefits available.

b. When the Marketplace determines the client is potentially eligible for a non-MAGI coverage group

The Department must:

- Accept the electronic account for the client who is assessed by the Marketplace as potentially eligible for a non-MAGI group, or when the client requests a full determination.
- Notify the Marketplace of receipt of the electronic account.
- Not request additional information or verifications from the client already provided in the electronic account.
- Promptly determine eligibility without requiring another application; ensure timeliness standards in Chapter 1 are met.
- Notify the Marketplace of the final eligibility determination.

2. Applications Taken by the Department

a. When the Department determines the client is eligible for Medicaid or WV CHIP based on MAGI

The Department must:

Promptly enroll the client into the MAGI coverage group. The client may also pursue eligibility for non-MAGI Medicaid coverage groups while enrolled in the MAGI group, see 16.3, B.

b. When the Department determines the client is ineligible for Medicaid or WV CHIP based on MAGI

The Department must:

- Promptly determine potential eligibility for Advance Premium Tax Credits and Cost Sharing Reductions (APTC/CSR) and transfer the client's electronic account to the Marketplace,
- Certify for the Marketplace the criteria applied in determining eligibility, and
- Provide the client with a combined eligibility notice, including notice of the Medicaid denial or closure and the transfer of their electronic account to the Marketplace.

c. When the Department determines the client is ineligible for Medicaid or WV CHIP based on MAGI, but are completing a determination for a non-MAGI coverage group.

The Department must:

- Promptly determine potential eligibility for APTC/CSR and transfer the client's electronic account to the Marketplace.
- Provide notice to the Marketplace that the client is not Medicaid or WV CHIP eligible based on MAGI, but that a final determination based on non-MAGI is pending.
- Provide notice to the client that the Department determined them ineligible for Medicaid or WV CHIP based upon MAGI standards, but are continuing to evaluate them for coverage for non-MAGI coverage groups. The client should be notified in simple language of their potential eligibility for non-MAGI coverage groups and the benefits available.
- Provide coordinated content in the notice including that the client's account was transferred to the Marketplace for an evaluation for APTC/CSR, and that enrollment in APTC/CSR will not affect their potential Medicaid eligibility.
- Provide the client notice of the final non-MAGI Medicaid eligibility determination. If the client is determined eligible for a non-MAGI coverage group, the notice should inform the client that the Marketplace will be notified of the client's eligibility, and that Medicaid eligibility will result in closure of APTC/CSR.
- Notification of the final eligibility determination based on non-MAGI must be also be provided to the Marketplace.

3. Coordination Between the Department and the Marketplace Involving Appeals:

The Department must establish a secure electronic interface so that

- The Marketplace can notify the Department when a client has requested a fair hearing; and
- The client's electronic account, including information provided as part of the appeal, can be transferred between the Department and the Marketplace.

When conducting a fair hearing, the Department should not request information or documentation from the client that is already included in their electronic account.

The Department must transmit to the Marketplace the hearing decision made by the Department.

H. APPLICATION PROCEDURES BEGINNING OCTOBER 1, 2013

The Affordable Care Act requires that Medicaid and WV CHIP agencies, and the Marketplace will begin accepting the SLA October 1, 2013. The Act also requires that no matter where the applicant submits the SLA, the Department or the Marketplace they will receive an eligibility determination for any insurance affordability program and be able to enroll in the appropriate coverage, if eligible, without delay. See Section 1.24,G regarding coordination requirements between the Department and the Marketplace.

1. Responsibilities of the Department

a. Accept applications and electronic accounts transferred from the Marketplace

Beginning October 1, 2013, the Department must:

- Accept the Single-Streamlined Application (SLA).
- Using the SLA, determine eligibility for coverage in current Medicaid and WV CHIP groups beginning October 1, 2013, or, for the Adult Group beginning January 1, 2014.
- Provide notice of the effective date of eligibility.
- Facilitate enrollment into coverage without delay for client determined eligible effective in 2013, or effective January 1, 2014 for the Adult Group.

The SLA does not provide sufficient information for the Department to determine eligibility for non-MAGI coverage groups. If the client indicates potential eligibility for a non-MAGI coverage group, the Department must provide the client with the DFA-SLA-S1 to obtain the additional information needed to determine eligibility. See Section 16.3,B for information regarding determining eligibility between MAGI and non-MAGI coverage groups.

b. Coordination with the Marketplace

Beginning October 1, 2013, the Department must:

- Accept electronic accounts transferred from the Marketplace for clients determined Medicaid or WV CHIP eligible based on MAGI,
- Facilitate enrollment into coverage effective January 1, 2014 for clients determined Medicaid or WV CHIP eligible by the Marketplace,
- Accept electronic accounts transferred from the Marketplace for a client that indicates on their application potential eligibility for a non-MAGI coverage group, for a full eligibility determination, see Section 16.3, B,
- Transfer to the Marketplace, without delay, the electronic account of clients determined ineligible for Medicaid or WV CHIP, but potentially eligible for APTC/CSR.
- Provide the client with notice and fair hearing rights.

2. Responsibilities of the Marketplace

a. Accept applications and electronic accounts transferred from the Department

Beginning October 1, 2013, the Marketplace must:

- Accept the SLA developed to determine eligibility for Medicaid, WV CHIP and APTC/CSR and Qualified Health Plans,
- Make eligibility determinations based on MAGI for coverage beginning January 1, 2014, and
- Provide appropriate notice and fair hearing rights to the client.

Clients will also be provided with information about the Department and how to apply for coverage beginning October 1, 2013.

b. Coordination with the Department

Beginning October 1, 2013 the Marketplace must:

- Make eligibility determinations based on MAGI for Medicaid or WV CHIP coverage effective January 1, 2014,
- Transfer the eligible client's electronic account to the Department, without delay, and
- Transfer to the Department for a full eligibility determination, without delay, the electronic account of a client that indicates on their application potential eligibility for a non-MAGI coverage group.

NOTE: Clients determined eligible during the initial open enrollment period, October 1, 2013 through December 31, 2013, with coverage effective January 1, 2014, will have a redetermination scheduled 12 months from the month of application, even though this certifies the case for less than 12 months.

NOTE: Clients determined eligible during the initial open enrollment period of October 1, 2013 through December 31, 2013, with coverage effective January 1, 2014, are required to report changes in circumstances that may affect their eligibility prior to January 1, 2014. The Department must evaluate the case based on any reported changes.