DUE TO DELETION OF MANUAL MATERIAL

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2.3 MEDICAID

Individuals who receive Medicaid experience the same kinds of changes between application and redetermination and between redeterminations as individuals who receive SNAP benefits 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. See Section 2.8 for children's Medicaid groups.

- For most Medicaid coverage groups, eligibility of AG members is determined on an individual basis. Therefore, the same change may impact each AG 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 months of continuous Children Under Age 19. See Section 2.8.

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

The Worker's case maintenance requirements for illegal aliens emergency Medicaid is usually limited and includes checking to determine if the emergency has ended. When the emergency is ongoing, usual case maintenance and redetermination policies of the coverage group for which the recipient is approved apply. If a Medical Review Team (MRT) decision was part of the client's eligibility determination, MRT redetermination requirements apply.

There are no case maintenance requirements for QDWI.

Specific items other than the eligibility determination are addressed here.

A. SOURCES OF INFORMATION

Sources are listed in Section 2.1.

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.

When a change is reported during the certification period which affects eligibility, the Department must only request the information on the change reported. When the information is received, the client is evaluated for rolling renewal. If the agency has enough information available to renew eligibility with respect to all the eligibility criteria, the agency must begin a new 12-month certification process.

EXAMPLE: A client is determined eligible from February 1, 2014 through January 31, 2015. On June 2, 2014 the client calls and reports a change in income. The information is provided to the Department on June 6, 2014. The Worker evaluates and determines enough information is available to renew eligbility. The benefit is given a new certification period effective July 1, 2014 through June 30, 2015.

EXAMPLE: A Redetermination for SNAP benefits is completed on May 14, 2014. The certification period is April 1, 2014 through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to recertify. The Medicaid certification period is renewed from June 1, 2014 through May 31, 2015.

When the determination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination. See the eRAPIDS User Guide.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

A. 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. See Section 2.8 for children's Medicaid groups.

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 or QI-1 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. See Section 2.8 for children's Medicaid groups.

When the address change is made after the deadline date, the change is effective 2 months after the change is made. See item 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.

When a family reports that a child is born or a child moves into the home and there is an existing Medicaid or WV CHIP AG, the Worker must evaluate the child's eligibility for all coverage groups and WV CHIP without requiring an application. Information to evaluate the child's eligibility may be obtained from the federal data hub, existing case information, or from a phone contact. After these methods are exhausted, information may be requested using an eRAPIDS verification list or DFA-6.

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. See Section 2.8 for children's Medicaid groups.

NOTE: When an individual cooperates with BCSE, he is added to the Medicaid AG or the AG is reopened effective the month following the month in which BCSE considers that the individual cooperated.

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

4. AG Closures

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

- Phase II of TM coverage expires
- Extended Medicaid coverage ends
- Medically Needy non-spenddown AG, not redetermined in the 6th month of eligibility
- Medically Needy spenddown AG's at the end of the POC

In no instance is Medicaid Coverage under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. A child is also evaluated for WV CHIP eligibility. This is done before the client is notified that his Medicaid eligibility will end. Eligibility is evaluated 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. The AG does not remain active while the MRT decision is pending.

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

EXCEPTION: Changes in income do not affect the eligibility of 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 Children Under Age 19 coverage. See Section 2.8

An AG which meets a spenddown remains eligible until the end of the POC in the following situations, regardless of whether or not the individual is an AG member.

- A member(s) of the Income Group experiences an increase in income; or

- An individual(s) with income is added to the Income Group; or

- An individual(s) is removed from the Needs Group

NOTE: For QMB, SLIMB and QI-1, the RSDI COLA's are disregarded in determining income eligibility for January and any subsequent months prior to the effective month of the state's FPL updates for the year.

5. Cost-Of-Living Increases In Federal Benefits

Recipients of federal benefits such as RSDI, SSI, Black Lung or VA Benefits may receive periodic cost-of-living increases (COLA's). RSDI/SSI increases are handled in accordance with instructions in Appendix B of this Chapter. All other federal benefit cost-of-living increases are treated as any other change, except that the client is not required to report the change.

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 is denied in error or a nursing home contribution is overpaid due to Worker error or failure to act promptly, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses paid by the client which would otherwise have been paid by Medicaid.

Reimbursement for out-of-pocket medical expenses is limited to 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 Medicaid application.

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 DFA Economic Services Policy Unit 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.
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When the request for reimbursement is denied, the DFA Economic Services Policy Unit notifies the CSM electronically of the decision. The local office notifies the client in writing of the denial.

2. Holding The Medicaid Card

Medicaid cards are not held under any circumstances.

3. Procedures For Cards Which Are Returned, Incorrect Or Not System-Issued

a. Returned Cards

Upon receipt of these cards, the State Office mails them to the appropriate local office.

When the address is incorrect, the Worker remails the card or gives it to the client when he learns the correct address. The correct address must be entered before deadline.

b. Incorrect Cards

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

c. Card Not System-Issued

When Medicaid eligibility is established in eRAPIDS, but a card is not system-issued, the Worker must complete a manual card, eRAPIDS 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 eRAPIDS. See instructions in Section 21.4 for completion of a manual card or verification letter.

4. Incorrect Eligibility Dates

When an incorrect eligibility period(s) is reflected in eRAPIDS, the Worker must follow the appropriate eRAPIDS 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 eRAPIDS 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.

eRAPIDS generates form EDA7 to the client to inform him of his correct date of eligibility.