1. 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.

2. 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.

3. 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.