



# COMBINED MEDICAID 1501-1 CASE MANAGEMENT – Reporting Changes

	CMA 1501-1
<b>Supersedes:</b>	FMA 1501-1 (07/01/06), MA 1501-1 (07/01/06)
<b>References:</b>	42 CFR 431.213; 435.916 and .919; ARM 37.82.101
<b>Overview:</b>	<p><u>GENERAL RULE</u>-- Medicaid clients are required to report changes as soon as possible, but within 10 days of their knowledge of the change.</p> <p>Clients may report changes at any time and are encouraged to report all changes even if they believe the change will not affect their eligibility.</p> <p>SSI eligible individuals have specific reporting requirement for both SSA and Medicaid. If an SSI Medicaid recipient reports a change to OPA, eligibility staff must act on that change. If the reported change affects SSI eligibility, refer the client to SSA.</p> <p>When changes are not reported or not reported timely, the client may be subject to an overpayment, and/or may receive incorrect benefits.</p> <p>Overpayments are evaluated using information as if it had been reported timely, and within the timeliness guidelines.</p>
<b>WHO IS REQUIRED TO REPORT?</b>	<p>Anyone receiving, applying or eligible for Medicaid is required to report changes in both their individual circumstances as well as their household's circumstances as well as their household's circumstances and provide necessary verification.</p> <p><b>NOTE:</b> The department will evaluate the reported change and notify the client if verification is necessary.</p>
<b>WHAT MUST BE REPORTED?</b>	<p>Changes that must be reported include:</p> <ol style="list-style-type: none"><li>1. Changes in income source or gross monthly income, including, but not limited to:<ol style="list-style-type: none"><li>a. Changes in hours worked or pay per hour/pay period;</li><li>b. Pay raises or pay cuts;</li><li>c. An additional job;</li><li>d. A different job;</li><li>e. Lump sum payments such as lottery winnings, settlements;</li><li>f. Disability/death benefits;</li><li>g. Child support payments (received or paid out).</li></ol></li><li>2. Someone moves into or out of the household;</li><li>3. Changes in residence and/or living arrangements;</li><li>4. Changes in resources (when cash on hand, stocks, bonds, and money in a checking or savings account increases or decreases);</li><li>5. Non-financial changes, such as:<ol style="list-style-type: none"><li>a. Pregnancy begins or ends;</li><li>b. Moving into or out of a nursing home;</li><li>c. Being determined disabled; and</li></ol></li></ol>

	<p>d. Waiver services begin or end.</p> <p>The date the change is reported is the new coverage request date. Retro coverage may be available, see CMA 104-1.</p> <p>6. New or changed health insurance coverage, premiums or other third party liability; and</p> <p>7. Changes in medical expenses, for medically needy and nursing home clients.</p>
<b>METHODS OF REPORTING CHANGES</b>	<p>Clients can report changes:</p> <ol style="list-style-type: none"> <li>1. Through their account at <a href="http://www.apply.mt.gov">www.apply.mt.gov</a>;</li> <li>2. By calling or writing the OPA or PAHL</li> <li>3. By completing a “Change Report Form” (HCS-260A); or</li> <li>4. In person</li> </ol> <p><b>NOTE:</b> Eligibility staff may discover information from other sources (e.g., interfaces, other agencies, etc.).</p>
<b>ACTING ON REPORTED CHANGES</b>	<p><b>Eligibility staff must act on all reported or discovered changes within 10 days of the date reported or discovered, whether timely or not.</b></p> <p>Acting on changes may include:</p> <ol style="list-style-type: none"> <li>1. Redetermining eligibility,</li> <li>2. Requesting verification and/or more information,</li> <li>3. Recalculating benefit/spend down amount,</li> </ol> <p><b>NOTE:</b> A spend down cannot be increased retroactively.</p> <ol style="list-style-type: none"> <li>4. Taking adverse action (reduction or termination of benefits),</li> <li>5. Establishing an overissuance, OR</li> <li>6. Simply documenting in system case notes that a change was reported/discovered, evaluated, and no further action was required.</li> </ol> <p><b>Eligibility staff must act on all changes within 10 days of receipt, even if ongoing benefits cannot be corrected prior to issuance.</b></p>
<b>VERIFICATION</b>	<p>When a client reports a change affecting eligibility or spend down amount, verification may be required.</p> <p>Staff must <u>always</u> follow up verbal requests with an eligibility system notice.</p> <p><b>NOTE:</b> Verification is not needed when the reported change will close current Medicaid coverage, and an ex parte review doesn’t indicate other eligibility.</p>
<b>ADDING A HOUSEHOLD MEMBER</b>	<p>When the county discovers or the client reports a new household member, the existing assistance unit(s)’s eligibility is redetermined by including the new member’s presence, income, resources, etc. as required by policy.</p> <p>The new household member can receive up to 3 months retro Medicaid from month</p>

	<p>their presence is reported/discovered, if ALL eligibility factors are met.</p> <p>All household members' eligibility must be redetermined based on the new household member's presence, even if the new member isn't requesting coverage. Adding someone to the household could affect a variety of factors, including filing/assistance unit, deeming, income and resources.</p> <p>Request verification (e.g., relationship, income, resources, etc.) necessary to determine existing household's ongoing eligibility.</p> <p><b>ABD:</b> If adding the new household member may affect the existing household's eligibility, verification of pertinent eligibility factors (e.g., income, relationships, resources, etc.) must be provided to accurately determine ongoing eligibility for all household members.</p>
<b>NOTICES ON ACTION TAKEN</b>	<p>Adequate notice can be sent when a change is reported on a signed paper or electronic change report form and enough information is provided to determine ongoing eligibility.</p> <p>Timely notice of adverse action is required when a change is reported by any other method, or when the signed HCS-260A does not provide other method, or when the signed HCS-260A does not provide.</p>
<b>CHANGES – VERIFICATION REQUIREMENTS</b>	<p><b>WITHOUT VERIFICATION:</b> When eligibility is affected by a reported/discovered change, but necessary verification is not included or available, request verification to be provided within 10 days of the notice date. If verification is not received prior to cutoff, or if the 10-day period extends into the following month, authorize benefits at the previous level Benefits are not increased (change SLMB to QMB, decrease spend down etc.) retroactively; ongoing benefits are increased once verification received.</p> <p>Unless an ex parte review indicates potential coverage under another health coverage program, Medicaid and/or HMK is closed without verification when the reported change will close current coverage.</p> <p>If it is unclear whether or not the reported change will close current Medicaid coverage, verification is requested to ensure eligibility is correctly determined.</p> <p>If necessary verification is not received by the due date, and ongoing eligibility cannot be determined, close Medicaid providing timely notice.</p> <p>If verification is received after the due date, but within the administrative month, redetermine eligibility and reopen and issue Medicaid, if appropriate.</p> <p><b>WITH VERIFICATION:</b> When verification is received with the reported change, redetermine eligibility within 10 days.</p>
<b>EFFECTIVE DATE:</b>	July 1, 2016