

Department of Public Health
and Human Services

Section:
CASE MANAGEMENT

FAMILY RELATED MEDICAID

Subject:
Redetermination

Supersedes: FMA 1502-1, 01/01/08

► **References:** 42 CFR 435.916 and .919, ARM 37.82.101, .205, .206 and 37.83.201; P.L. 111-3

► GENERAL RULE -- A redetermination is a review of all financial and non-financial requirements affecting eligibility, which may include income, resources, household composition, health insurance coverage, HIPP compliance, alien status, etc., depending on the group(s) the individuals may fit into.

Information that is not subject to change, such as US citizenship, date of birth, SSN, etc., does not usually need to be reviewed. However, if a recipient's Social Security Number has not been verified via interface by the next scheduled redetermination, other action must be taken to verify the Social Security Number.

► It may be necessary to review identity documentation of children when they reach age 16 because picture ID becomes a requirement at age 16 unless identity has been verified through SVES interface.

Redetermination of eligibility for all recipients occurs:

1. Upon knowledge of anticipated changes in the filing unit's situation;
2. Promptly after a report or discovery of changes in the filing unit's situation;
3. Periodically for time-limited situations such as home maintenance allowances, intent to return home disregards of home property, conditional assistance periods, etc. and
4. At least once every 12 months.

► Annual redeterminations may be scheduled to coincide with income events such as receipt of lease payments or self-employment tax filing, to coincide with redetermination of household SNAP or TANF benefits, or to coincide with the end of a continuous eligibility period.

Timely notice must be given in all instances of adverse action (such as closure or increased incurment) as a result of a redetermination. Adequate notice is given if benefits are unchanged or the incurment is

decreased. (MA 1503-1) A system change report notice will be sent to the household when each redetermination is completed.

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**REDETERMINATION
REPORT**

All recipients receive form HCS-272 'Redetermination Report' by the first of the month in which redetermination is scheduled in the system. The form indicates that whatever information is required is due by the 8th of the month in which the redetermination is due. HCS-220 and HCS-101 are also sent to the household as a part of the redetermination process.

The redetermination report is populated with the information known to the Department as entered in the system. Recipients are instructed to update any information that has changed and enter any new information that is not reflected on the report.

The report is not required to be returned to the OPA, under any circumstances. It is a tool used to communicate information between the OPA and the recipient/household. An adverse action cannot be taken simply because the report form was not returned, completed or signed.

If a redetermination report is returned as undeliverable, the reason for the return and the information provided by the post office must be treated as a change in circumstances. If the returned document includes a forwarding address in Montana, update the case address in the system, re-mail the form to the new address, and also separately send a request for information regarding the discovered change. If the returned document includes a forwarding address outside of Montana, update the household address and state residency in the system, close benefits and send timely notice of adverse action to the new out-of-state address. If the returned document does not include a forwarding address, close the case for loss of contact and send adequate notice of adverse action to the last known address. Case note all actions.

► **ANNUAL
REDETERMINATION
REQUIREMENTS**

A complete eligibility redetermination is required at least once every 12 months for each Medicaid recipient.

Depending on the circumstances of the individual recipients within the household, a redetermination may be passive or active:

- A passive redetermination, referred to as an 'administrative redetermination' is a process in which the recipient is only required to report changes in their circumstances. If there are no changes, the recipient is not required to confirm, verify or respond to the redetermination form/notification.
- An active redetermination, referred to as a 'traditional redetermination' is a process in which the recipient is required to re-verify all

circumstances which are subject to change, including liquid resource values, changed non-liquid resources, all income, etc.

Medicaid recipients subject to **administrative redetermination**:

- Individuals age 18 or under, regardless of program,
- Individuals age 19 and older who are not receiving waiver or institutionalized coverage.

Medicaid recipients subject to **traditional redetermination**:

- Individuals age 19 and older who are receiving waiver or institutionalized coverage.

For SSI cash recipients, Social Security Administration completes the annual review for SSI recipient Medicaid coverage. The eligibility case manager completes redetermination for all other groups, including for Medicare Savings Program benefits provided to SSI recipients.

► ADMINISTRATIVE REDETERMINATION

Administrative redetermination is a passive redetermination process in which the recipient/household is sent a redetermination report/form which identifies the household circumstances as known to the OPA. The household/recipient is required to review the information on the form, and only report to the OPA changes to the information.

An interview may not be required for an administrative Medicaid redetermination, although an interview must be scheduled if requested by the recipient. It must be made clear to the recipient that the interview is not required.

If the recipient/household has no changes to report, they are not required to contact, communicate with or verify information to the OPA. No contact from the recipient is to be interpreted to mean 'no change in circumstances'.

If the recipient/household reports changes that will not impact on-going benefits (change the level of coverage), no verification of the change is required. Example: If HMK-Plus household reports a change in income and they are in the midst of a 12 month continuous span, no verification of the income is required.

If the recipient/household reports changes that will potentially impact on-going benefits (reduction in level of coverage, termination, increase in benefits), verification of the change is required. When verification is not submitted with the reported change and the reported change could result in an increase in benefits to the recipient/household, a request for information will be sent. If the reported change would result in a negative action, send a request for information if timely notice of

adverse action would still be possible by the due date on the notice. If timely notice would not be possible by the due date on the request for information notice, benefits will be closed using timely notice; include in the comments section of the negative action notice that if verification is received before the effective date of closure, the information will be used to reconsider eligibility.

Available queries will not routinely be reviewed as part of an administrative review. However, if the household reports a change that may be verified by use of an available query, that query can be used to verify the change.

When the administrative redetermination is complete, send the household/recipient the "Redetermination Complete" notice from the system. If the redetermination resulted in a change to coverage of any household member, also send an appropriate notice of change, being mindful of timely notice requirements if the change is an adverse action.

NOTE: When an HMK Plus individual has a redetermination that does not align with their 12 month continuous eligibility span, the Medicaid should be reauthorized and the redetermination date may be reset to align with the end of the 12 month continuous eligibility span.

► TRADITIONAL REDETERMINATION

Traditional redetermination is an active redetermination process in which the recipient/household is sent a redetermination report/form which identifies the household circumstances as known to the OPA. The household/recipient is required to review the information on the form, and report to the OPA changes to the information. The recipient is also required to provide documentation of household circumstances that are subject to change, such as liquid asset values, income, etc.

In a traditional redetermination, regardless of whether the recipient/household has changes to report, the recipient is required to verify information to the OPA. No contact from the recipient will result in closure of benefits. Traditional redeterminations are required for recipients age 19 and older who are receiving waiver or institutionalized coverage.

An interview is not required for a traditional Medicaid redetermination, although one may be requested at the case manager's discretion. It must be made clear to the recipient that the interview is not required. An interview must be scheduled if requested by the recipient. Failure to appear for a requested interview is not cause for closure of benefits if all necessary information has been provided.

All eligibility factors that could potentially impact on-going benefits must be verified whether a change is reported or not. When a traditional redetermination is required for a recipient, the eligibility case manager will send a request for information (400M) specifically identifying information known to the OPA that must be verified. If the recipient/household reports additional changes during the redetermination process, additional requests for information may be required. However, under no circumstances should a request for information be sent with a due date that would not allow for timely notice of adverse action to be sent notifying the household of a closure effective at the end of the month in which redetermination is due. Extensions for providing information cannot be granted for redeterminations because of the requirement to provide timely notice of adverse action. If a recipient provides partial documentation prior to a closure action, it is not acceptable to send a request for information if the information due date will not allow for timely notice of closure if the information is not received. In the case of partial but incomplete verification being provided, send a closure notice, and in the comments section, tell the client what information is missing and that information provided prior to the effective date of closure will be 'considered'.

As part of the traditional redetermination process, all applicable queries should be reviewed for all required filing unit members. This may include MISTICS, SOLQ, SEARCHS, vehicles, POSSE, and others as available. Information gathered from the queries will be compared to the information on file. If the information from the queries indicates a change (whether reported or unreported by the household), verification will be requested from the household.

When the traditional redetermination is complete, send the household/recipient the "Redetermination Complete" notice from the system. If the redetermination resulted in a change to coverage of any household member, also send an appropriate notice of change, being mindful of timely notice requirements if the change is an adverse action.

► REQUESTING INFORMATION

If the household reports a change or, in the case of a traditional redetermination, queries or other information indicate a change in the household's circumstances which could affect eligibility, the case manager will send a system notice requesting information and/or verification necessary to process the redetermination.

If all information necessary to determine continuing eligibility is not received by the date due, benefits are closed via timely notice. If all information is then provided after closure notice has been sent, but before the effective date of closure, the redetermination must be processed, and if the recipient/household is eligible, benefits are reopened. If only some,

but not all, necessary information is provided before the effective date of closure, the benefits remain closed. DO NOT SEND a new pending notice!!! Send a 'courtesy notice' (230M – "Medical Assistance Remains Closed). If the information is not provided until after the effective date of closure, a new application is required if the case is closed; if some household members remain in open status, a new coverage request is required.

Timely and adequate notice of adverse action must be sent according to policies in FMA1503-1 if benefits are terminated or reduced. The action must be documented in system case notes.

► EX PARTE REVIEW

Part of the redetermination process is conducting an ex parte review. When a Medicaid recipient's eligibility for his/her current benefits end for any reason other than at the request of the recipient, state residency or death, eligibility for other types and levels of Medicaid coverage must be evaluated. This process is referred to as an ex parte review, and must be case noted for each Medicaid closure.

An ex parte review should be based on the information already available in the existing case file and through queries. If changes have been reported, or additional eligibility factors must be evaluated for other Medicaid coverage groups, verification of the additional factors may be requested from the household or obtained by the eligibility case manager before the ex parte review is completed. However, the ex parte review **MUST** be completed before the effective date of closure, and therefore requests for additional information must have due dates which are no later than would allow for timely notice of adverse action.

If the case file contains adequate information and necessary verification of reported changes, eligibility for other Medicaid coverage groups will be determined at the time of the existing Medicaid coverage group closure. If the case is found eligible for another Medicaid coverage group, a new application may not be requested or required, and the "new" Medicaid coverage should be authorized. Occasionally, it may be helpful to obtain a Medicaid redetermination form from the household to use as a tool in determining eligibility for new Medicaid coverage, but cannot be required.

NOTE: When changing a recipient from one Medicaid coverage group to another with exactly the same benefits (for example, from Child Newborn to HMK *Plus*), it is not necessary to send a closure notice for one program and an approval for the new program. As long as the individual's eligibility continues at the same level of coverage and is determined timely, there is no change from the client's perspective.

If the household fails to provide necessary proof of reported changes by the effective date of closure, the ex parte review is complete and the individual's coverage remains closed. The ex parte process and the outcome must be case noted in the system.

**► COMBINATION
CASE**

When a case includes some recipients who are subject to administrative redetermination and other recipients who are subject to traditional redetermination, follow procedures for each type of redetermination at the individual recipient level. For example, if a household includes a father in an institution, and a mother and a child and the whole family is on Family Medicaid, the father is subject to traditional redetermination; the mother and the child are subject to administrative redetermination. If the father fails to provide documentation of all eligibility factors, his institutionalized coverage will end. However, the Family Medicaid would continue because without institutionalization, he is still eligible for Family Medicaid and so is the rest of the family if they have reported no other changes. In this situation, the father's institutionalized coverage will be ended in CHIMES by ending the pre-admission screening span with the last day of the current benefit month, and timely notice of adverse action will be sent on the closure of institutionalized coverage. The 'redetermination complete' notice will be sent also confirming that the Family Medicaid without institutionalized coverage will continue. If he complies with the traditional redetermination requirements before the closure effective date, remove the end-date from the pre-admission screening span. If he complies after the effective date of institutionalized coverage, a new screening form will be needed and will be entered with an effective date of the first of the benefit month in which the coverage request and cooperation were completed. Case note all actions and reasons thoroughly.

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