

Indiana Health Coverage Program Policy Manual

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**Continuing Case Processing**

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## 2200.00.00 CONTINUING CASE PROCESSING

This chapter contains policy regarding continuing case processing, including:

- Redeterminations (Section 2205);
- Changes (Section 2215);
- Processing Changes (Section 2220);
- Adding an Individual to the AG (Section 2225);
- Timely Notice of Adverse Action (Section 2232);
- Changes in Category of Assistance (Clevidence Ruling) (Section 2235);
- Reduction in Scope of Medicaid Coverage (Section 2236);
- Suspension of Medicaid Benefits (Section 2237);
- Discontinuance (Section 2238);
- Correction of Spend-down and Liability (Section 2239);
- AG Address Change (Section 2240); &
- Voluntary Withdrawal from Assistance (Section 2250).

## 2205.00.00 REDETERMINATIONS

Periodic reviews of eligibility must be made on assistance cases to ensure that benefits are computed correctly. The requirements for redeterminations are discussed in this section.

A redetermination is the process in which the caseworker gathers information on the circumstances of the case members and verifies all changeable elements to establish continuing eligibility.

In general, during a redetermination the following must occur:

- A new redetermination summary, which is considered the Eligibility Review Form, containing current information is printed and signed by the individual or authorized representative; and

- All changeable eligibility factors for the AG are verified.

If the income has been verified within the last 30 days, then no new income is required and should not need to be requested. If the income is older than 30 days, then the member must verify income as requested on the redetermination summary.

Individuals eligible under MASI are not required to complete a redetermination with the DFR.

#### **2205.05.00 ESTABLISHING THE REDETERMINATION MONTH**

The redetermination month is the month during which eligibility for all assistance groups in a case is reinvestigated. Federal regulations define the maximum time frames for completion of redeterminations for each program. If there are multiple AGs in the case, the redetermination month is established at the earliest required interval based on the following requirements:

For MAGI Medicaid, different individuals within the same AG may have different redetermination periods; AGs under MAGI-based income must be redetermined once every 12 months, and no more frequently than once every 12 months;<sup>1</sup>

For Non-MAGI Medicaid, a redetermination must be completed at least once every 12 months;<sup>2</sup>

The Non-MAGI Medicaid categories redetermination periods cannot exceed 12 months but can be shortened to align with other TANF or FS within the same AG.

#### **2205.10.00 SCHEDULING REDETERMINATION INTERVIEWS**

Interviews cannot be required for MAGI or Non-MAGI Medicaid recipients who are having their eligibility redetermined.

#### **2205.15.00 REDETERMINATIONS BY MAIL**

A redetermination may be completed by an in-office or telephone interview, or by mail using the system generated Eligibility Review Form. All members will receive the system generated Eligibility Review Form as the preferred method for conducting redeterminations. An in-office or phone interview for recipients of Medicaid/Hoosier Healthwise is not required, but it is an available option. If a Medicaid member requests an office or phone interview, one must be granted.

For MAGI-Medicaid only cases, the agency must make a redetermination of eligibility without requiring information from the individual, when possible. The redetermination is based on reliable information contained in the individual's account or other more current information available to the agency (such as work number).

If the agency is unable to automatically redetermine the eligibility of the individual, then an Eligibility Review Form is mailed to each Medicaid individual that is being redetermined.

The non-asset version is used when all assistance groups in a case are Hoosier Healthwise or HIP members that have no asset or resource requirements. The mailer includes a cover page with information about the process and instructions for returning the form.

The asset version is used when one or more of the AGs in a case have an asset or resource requirement. For example, if the members in a case are MA 2 and MA D, the asset version of the form is mailed. The mailer includes a cover page with information about the process and special circumstances involving asset disclosure, as well as instructions for returning the form.

The Eligibility Review Form is sent to the adult AG payee or parent/caretaker of a child AG. If a child is the only case member and there is no authorized representative, the form is sent to the child. A Notice of Redetermination (NOR) is sent to the other adult AG payees and authorized representatives listed as "ongoing" in the case informing them that the Eligibility Review Form has been sent. The NOR identifies the recipients who are being reviewed and the due date listed on the Eligibility Review Form.

## **2215.00.00 CHANGES**

The individual may report a change in circumstances or the DFR may learn of a change which could affect eligibility or the benefit amount. The worker is responsible for promptly evaluating the change and taking any indicated action to adjust the benefit. A person eligible under MASI reporting changes to DFR should be informed that the reported change (i.e. change of address) should also be reported to the Social Security Administration.

Changes in circumstances include, but are not limited to:

- Changes in income;

- Changes in composition of the AG;

- Changes in living arrangement;

- Changes in resources;

- Changes in the legal obligation to pay child support;

- Changes in household tax relationship or tax filing status;

- Changes in health insurance coverage.

## **2215.10.00 DATE CHANGE REPORTED**

The date a change is reported is the date on which an individual reports the change in person, by phone, by fax, or in writing to the Local Office or Document Center. This includes speaking directly to the worker or other staff member and leaving messages for the worker. All reports of changes are to be accurately documented in Running Record Comments and should be entered in ICES the same day the change is reported. ICES establishes the date that the information is entered in the system as the date it was reported. The "occur date" is the date on which the change actually occurred.

## **2215.15.00    WORKER RESPONSIBILITIES REGARDING CHANGES**

Prompt action must be taken on all changes to determine if they affect eligibility. The case record must include the date the reported change was received, whether the change was reported by mail, telephone, the DFR Benefits portal, fax, or personal visit, the nature of change and any other appropriate information. The worker must take appropriate action on all reports of changed information promptly but no later than 10 days from the date of the receipt of the change.

The individual must be notified of any change in eligibility or benefit. In addition, if the change was reported by the AG, the AG will be notified even if there is no change in eligibility or benefit amount.

If the worker is made aware of discrepant information or information that could affect eligibility or level of benefits, but lacks enough information to determine the effect, he will issue a request for verification. This request should be issued on the date of receipt of the change if at all possible, outlining the needed information or verification, and giving the AG 13 days from the date the notice is issued to provide the information.

If the AG provides the requested information or verification within the designated 13 day period, the worker will take appropriate action. If the AG refuses to provide the requested information or verification within the designated 13 day period, the worker will, on the first day following expiration of the 13 day period, take action to recalculate eligibility and authorize the appropriate action for each AG. The worker must enter the appropriate reason code on AEWAA which reflects the element which the AG did not verify.

If a potential change in medical expenses is identified when the AG presents verification of expenses to meet the spend-down, the AG may be asked to confirm if a change has occurred. If the AG voluntarily provides all verification and information necessary to process the change, including the frequency of any new expenses and possible third party liability, the change must be processed. If the AG is unable or unwilling to provide the necessary information/ verification, the change cannot be processed because the AG is not required to report or provide verification of medical expenses.

All medical expense changes identified from sources other than the household will not be acted upon unless all necessary verifications are obtained and action can be taken without contacting the AG.

## **2220.00.00    PROCESSING CHANGES**

Individuals are given 10 days to report the change, 13 days to verify the change, and if the action is negative, 10 days (plus three days for mail delivery) timely notice of adverse action. If the individual is doing all that he can to cooperate in verifying the information but is unable to do so, an extension may be granted or the DFR may accept the responsibility of verifying the information. Document the reason for any extension in Running Record Comments. In either

instance, if the individual and the worker are unable to adequately verify the information within a reasonable time, the worker is to use the best available information to process the change and document in Running Record Comments.

When it becomes necessary to take adverse action (that is, reduce the benefit level) on an AG, there must be time to give advance notice of the adverse action. This is referred to as timely notice. The time period is 13 calendar days for all programs.

The following sections discuss change processing.

## **2220.05.00 CHANGES REPORTED AND VERIFIED TIMELY**

When a change is reported within 10 days of the date the change occurred and is also verified within 13 days of the report date, action is taken as indicated below.

When a change results in a positive action or increases the level of benefit, including the addition of a mandatory AG member, the effective date of the change is the month following the month the change was verified. If the Eligibility System does not form the new benefit of as of the first following month, then the case should be reviewed for a possible fiat or override.

Positive changes are changes that will increase the level of benefits and include verification that a member moved into a nursing facility, reductions in income and additions to the household. If a reported change is received stating that a member moved into a nursing facility, this is considered a verified change. If all other eligibility criteria is met (including the data gathering interview, all verifications received etc.), then the MA D category change will take place going forward to the next month.

### **Example 1:**

On 03/01, a healthcare application is received for a disabled applicant; the applicant does not receive SSDI or SSI and there is no MRT determination. The applicant/AR is requesting dual processing for HIP and MA D.

On 03/15, the HIP is approved and the POWER account is paid; the HIP is open 03/01.

On 03/27, verification that the member moved into a nursing facility is received, but the case is still pending a disability determination. On 04/02, MRT approves the MA D and the case is authorized. Due to adverse timeframes, the HIP is ending 04/30 and the MA D is opening 05/01, but because the reported change of residing in a nursing facility was received 03/27, then the MA D should open 04/01. In this situation, contact the Help Desk/PAL to end the HIP effective 03/31 so a fiat or override can be completed for MA D starting 04/01. The HIP will remain in place for the month of March.

**Example 2:**

On 03/01, a healthcare application is received for a disabled applicant; the applicant does not receive SSDI or SSI and there is no MRT determination. The applicant has a pending waiver application. The applicant/AR is requesting dual processing for HIP and MA D.

On 03/15, the HIP is approved and the POWER account is paid; the HIP is open 03/01. The waiver approval is received 03/25, and on 04/27, MRT approves the MA D.

Due to adverse timeframes, the HIP is ending 05/31 and the MA D is opening 06/01, but because the waiver approval was received 03/25, then the MA D should open 04/01. In this situation, contact the Help Desk/PAL to end the HIP effective 03/31 so a fiat or override can be completed for MA D starting 04/01.

**Example 3:**

On 07/25, an individual reports that their last day of work was 7/16 and the last paycheck will be received 7/26. The recipient provides a statement from the employer on 7/30 (within the 13 day guideline). The earnings are removed from the budget effective 8/01 and any increase in benefits will take place in the 08/01 budget, even if the authorization occurs after adverse.

If the AG's benefit level decreases, or the AG becomes ineligible as a result of the change, the decrease in the benefit level is effective according to the normal adverse processing guidelines. Using the same example as above, if the change was verified on 07/30, then the decrease in benefits would take place in the 09/01 budget.

There are a few exceptions to this:

- For women who become pregnant and are receiving coverage for Family Planning Services under MA E, if the woman reports that she is pregnant, eligibility for MAGP will need to be determined and coverage may be granted retroactively without requiring another application being filed. In such situations, the appropriate DFR staff member would need to contact the Help Desk/PAL regarding the situation as a fileaid would need to be done, if appropriate, to end date the MA E coverage so MAGP coverage could be granted.
- For an ongoing MA I recipient, if the member enters a nursing facility or is approved for a waiver, a review of the retroactive MA months should be completed to verify if the recipient is eligible for a full coverage category. After a thorough review of both income and resources is completed, and it has been determined that the recipient is eligible for retro months, then the assigned DFR staff member would need to contact the Help Desk/PAL regarding the situation as a fileaid would need to be completed, if appropriate, to end date the MA I coverage so the full coverage MA could be granted.



- When a member reports a change after adverse that changes their PAC amount, the PAC changes will follow Adverse processing rules. This is because the member's Managed Care Entity (MCE) does "prospective billing" for POWER Account Payments, which means the member will have already been invoiced for following months. In order to reduce member confusion and possible system issues the new PAC amount, whether positive or negative, will not go into effect retroactively and does not need to be adjusted for current or past months.

The PAC change will be effective using normal Adverse (see 2232.00.00) rules if it is a negative change.

If the change is positive, it will be effective as of the next recurring month of eligibility that the system forms ("Recur"). If there are fewer than six days left in the month, the system has already formed the benefit for the immediately following month and will push the change forward.

#### **Examples:**

- A member reports an increase in income and it is verified on 5/20. The MCE has already sent invoices for May and June coverage. Using normal Adverse rules (see 2232.00.00), the new PAC amount will go into effect 7/1.
- A member reports a decrease in income and it is verified on 5/1. The MCE has already sent the invoice for May coverage. Using normal Recur rules, the new PAC amount will go into effect 6/1.
- A member reports a decrease in income and it is verified on 5/29. The MCE has already sent the invoices for May and June coverage. Using normal Recur rules, the new PAC amount will go into effect 7/1.

If an ongoing HIP AG is determined eligible for a MED 1 or MED 4 category, then change processing guidelines must be followed. If the category change is processed after adverse, but before the end of the month, then please contact the Help Desk/PAL to remove the ongoing months of coverage. Retro months can't be removed.

**In situations of dual processing, it is important to inform the applicant/AR that HIP coverage will not be removed retroactively. For applicants that are in a nursing facility or are in the process of being approved for a waiver, it is best practice to pursue the MA D process as opposed to processing for HIP coverage.**

If a recipient is in a nursing home and was on HIP, a deviation can be completed for medical expenses incurred in a retro month that the recipient was eligible for HIP coverage, if the claim was not a HIP covered service. See IHCPPM 3455.15.10.

It is the provider's responsibility to work with the Managed Care Entity (MCE) regarding billing issues, up to and including obtaining prior authorization. If a provider was denied prior authorization or a bill was denied by the MCE, the provider must exhaust all grievances and appeals with the MCE before requesting the HIP removal. If the provider disagrees with the MCE determination, then this should be appealed with the MCE, not with the DFR.

If a request to remove retro HIP coverage is received, then the removal will be reviewed on a case by case basis. If an actual provider generated bill, or copy of such a bill, is submitted that clearly shows that the provider has billed the Managed Care Entity (if applicable), that the claim was denied, and that the provider has exhausted all appeals and grievances with the MCE, then these can be reviewed by PAL for possible HIP removal; HIP removal is not guaranteed. Please send to the Help Desk/PAL for a policy determination.

#### **2220.10.00 CHANGES REPORTED UNTIMELY YET VERIFIED TIMELY**

If a change is not reported within 10 days yet is verified within 13 days following the report date, action is taken as indicated below:

When the change results in an increase in benefits or other positive action, the change is effective the month following the date reported and verified.

**EXAMPLE 1:**

An individual who is required to pay a premium for health coverage is fired from his job on 6/3 and received his last paycheck on 6/23. He calls to report the change on 6/28. On 7/3 he faxes in his last paycheck stub. The caseworker verifies by phone that his last day was 6/3 and his last pay was 6/23. The loss of earnings are reflected 7/1 with a supplemental benefit of either a lower premium or no premium for health coverage beginning 7/1.

When the change results in a decrease in benefits or the AG becomes ineligible, the change is effective the month following the expiration of timely notice.

**EXAMPLE 2:**

An individual begins a job on 5/26 which he reports on 7/19. His earnings require the payment of a premium for health coverage effective 9/1. Recovery is pursued for July and August. Refer to Chapter 4600.00.00.

## **2220.15.00 FAILURE OF ASSISTANCE GROUP TO REPORT CHANGES**

If the DFR discovers that the AG failed to report a change as required above and as a result received benefits to which it was not entitled, a referral is made to Benefit Recovery (BV) on screen BVBR to initiate claim determination and benefit recovery.

## **2220.20.00 Changes reported and NOT verified timely**

When a member reports a change which would increase their benefit or decrease their PAC/premium/liability, and it is reported but not verified by the 13<sup>th</sup> day, the benefits should continue at the current amount until after the untimely verifications are provided. If they are not provided, the benefit should be left at the previous level.

### \*For example:

A member reports a decrease in countable income from a job that has already been verified. The worker then sends a 2032 giving the member 13 days to verify the new income. If the decrease in income is not verified within the 13 days the worker should leave the income at the previous reported/verified amount and reauthorize the case.

When the untimely verifications are provided, the change should be implemented from the date the verification was provided rather than the date the change was reported. Normal adverse/recur logic applies.

## **2220.25.00 PROCEDURES WHEN MEDICAID FACILITY LOSES CERTIFICATION**

When a Medicaid-certified long term care facility receives notification from the Department of Health that its Medicaid provider agreement will be terminated a copy of the notification is sent to the Local DFR Office. Generally, the facility is given 30 days advance notice of the loss of certification. However, the facility does have appeal rights. If the facility appeals and the Department of Health rules that the patients are not in immediate and serious danger, the facility's Medicaid certification may be allowed to continue during a specified period of time while the deficiencies cited by the Department of Health are being remedied.

The DFR will need to stay in close communication with the facility concerning the facility's continuing Medicaid certification. Steps to change the recipients' data in ICES (Screen AEIII) should not be undertaken immediately by the worker upon receipt of the initial decertification letter. The facility's appeal status and any subsequent rulings of the Department of Health must be ascertained. If the worker cannot obtain the necessary documentation from the facility, the Central Office, Policy Answer Line, should be contacted.

## **2225.00.00 ADDING AN INDIVIDUAL TO THE AG (MED 2, MED 3)**

When a request to add an individual to the AG is received or a mandatory AG member enters the home, all eligibility factors must be reviewed.

Neither an application nor an interview is necessary, but all of the required information and verification regarding the new member must be obtained in order to make an eligibility determination and add him to the AG.

The new member is entered on AEIID. Pertinent information is then added to the appropriate screens as they appear. The system will generate a notice to inform the AG of the results. If adding a non-participating mandatory member causes the individual to lose Medicaid eligibility, ICES will explore continued Medicaid eligibility under other categories.

To provide the new member with retroactive coverage, it will be necessary to fiat to create an AG (consisting solely of the new person or persons) for the retroactive months. The sequence number to be used for the retroactive AG will depend upon the number already in use for the first AG. If the sequence number for the original AG is 01, the sequence number for the fiated AG will be 02. Additionally, it is important to remember to end-date the fiated AG appropriately.

#### **2225.10.00    ADDING A NEWBORN CHILD**

An infant born alive to a woman enrolled in any MA category except MA10 is deemed eligible for Medicaid without an application for the infant being submitted. The baby is to be immediately added to ICES upon the agency receiving notification of the birth. Refer to Section 2428.00 for more information regarding eligibility in the Newborn category.

Health coverage under the Newborn category is effective the first day of the month in which the child is born and continues for 12 consecutive months. The only allowable reasons to discontinue MA before the end of the 12-month Newborn period are 1) the child no longer lives in Indiana, 2) the child's parent or caretaker provides a written voluntary withdrawal statement, or 3) the child dies. Newborn coverage continues regardless of whether the infant continues to live with the birth mother or whether the child ever lived with the birth mother in the case of adoption or other custody arrangement. However, if the child is adopted and the names and location of the adoptive parents are unknown, the child can only be covered for the duration of the hospitalization starting with the month of birth. If the infant has not been named, the name assigned to her/him by the hospital for identification purposes, should be used.

Information sufficient to enroll the infant in the Newborn category is the child's name, sex, and date of birth. Birth notification may be made by the parent; however, notification is also to be accepted from the hospital, authorized representative in the case, medical provider or Hoosier Healthwise health plan that can knowingly provide the required information.

When the 12-month Newborn coverage period expires, eligibility under other medical categories must be explored and verified. The child was deemed to have applied at birth, and therefore an application cannot be required in pursuing a category change.

Newborn coverage does not extend to babies born to mothers covered under the MA 10 category (Hoosier Healthwise Package C). However, upon request by the parent/caretaker or other notification of the birth, an application is to be immediately provided or mailed to the family, or information given about obtaining an application from the internet. Hospitals and other Indiana Medical Providers that are Hoosier Healthwise enrollment centers should be encouraged to take the applications for newborns. They will know the eligibility status of the mother by using their Eligibility Verification System, which will indicate the benefit package of the mother.

#### **2232.00.00 TIMELY NOTICE OF ADVERSE ACTION**

Recipients must be given timely, advance written notice of any adverse action. In most circumstances, "timely" is 10 days (plus 3 for mailing) before the date the action is effective. The 3-day mailing period starts the day after the notice is mailed. The monthly Adverse Action dates are located on table TBIC. The Medicaid program has provisions which allow for exceptions to the 10 day (plus 3 for mailing) timely notice period. The following sections explain the MED timely notice exceptions.

Workers should carefully choose the reason code to be entered on AEWAA. It must be appropriate to the category and if timely notice is not required, enter a code with a priority of 1 on the TSRC Table. If a negative code in addition to the 650 code is not already displayed, the worker will be required to enter one. It is necessary to select the reason code carefully so that the notice will correctly reflect the reason benefits are terminating.

#### **2232.10.00 EXCEPTIONS TO TIMELY NOTICE (MED)**

The following situations do not require timely notice, but do require notice to be sent no later than the effective date of action:<sup>3</sup>

The DFR has factual information confirming the death of a recipient;

The DFR has received a written voluntary withdrawal of assistance; or

The DFR has verified that the recipient has been accepted for assistance in a new jurisdiction (county, state, territory or commonwealth).

#### **2235.00.00 CHANGES IN CATEGORY OF ASSISTANCE (Clevidence Ruling) (MED)**

When a Medicaid recipient loses eligibility under their current category of assistance, eligibility under all potential categories must be explored. If the case record contains information that a recipient is potentially eligible in another category, a new pending

category will be formed by the Eligibility System according to the recipient's recorded information reflected in their case file and the Medicaid categorical hierarchy (see IHCPPM 2035.30.00). If the income in the case has been verified within the last 30 days, then no new income will need to be requested. If the income is older than 30 days, then a 2032 will need to be sent out requesting the current 30 days of income. **MEDICAID MUST NOT BE INTERRUPTED WHILE A DETERMINATION IS BEING MADE CONCERNING THE RECIPIENT'S ELIGIBILITY IN THE NEW CATEGORY.**

If there is no information indicating possible eligibility under another category, Medicaid is to be discontinued. If the recipient is found to be ineligible in the newly formed category, Medicaid is to be discontinued. When eligibility is to be discontinued, a discontinuance notice is mailed to the recipient, which contains a list of all applicable categorical groups. If the client supplies information indicating potential eligibility under another categorical group prior to the recipient's effective date of discontinuance, Medicaid eligibility must be reinstated while eligibility under the new potential category is being determined.

When a change is reported that results in a new Medicaid category, Medicaid benefits continue without interruption. The worker must ensure that the proper reason code is entered for any adverse action, such as the imposition of a spend-down, liability, or premium. If the person is required to pay a CHIP or MED Works premium, continued eligibility is conditional upon the first day of the first month the premium categorical coverage begins. Whenever there is an adverse action, recipients must be given timely notice before the effect of the adverse action takes place. Please, refer to IHCPPM 2232.00.00.

If the eligibility status for a recipient under a new category is pending because of missing verification(s), the worker must send the Medicaid Category Change Form, FI 0017, to the client. Form FI 0017 must be completed by a worker and sent to the recipient with a 13-day deadline. If the additional information that is needed is more than what can fit on the FI 0017 Form, then an additional 2032 should be sent along with the FI 0017 Form. If the client fails to contact the DFR by the due date specified on Form 0017, Medicaid is to be discontinued. If the client contacts the DFR any time after receipt of the discontinuance notice and provides information which was specified on Form 0017, the client must come into compliance prior to the effective date of discontinuance to have eligibility continued. (Refer to IHCPPM 2040.00.00). If the DFR is contacted after the effective date of discontinuance, the client will have to re-apply.

Once a recipient responds timely providing additional information to continue eligibility and provides sufficient verification to determine eligibility under the new category, Medicaid eligibility continues without interruption. If the recipient provides information indicating possible eligibility under another category but does not provide sufficient verification, FI 2032 must be sent providing a 13-day deadline requesting the new verifications needed for eligibility determination under the new category. If the missing

information is not returned by the due date on the 2032, Medicaid eligibility is to be discontinued.

If the missing information is related to blindness or disability not being verified (see IHCPPM 2412.10.00 and 2412.30.00) for the recipient, then DFR must schedule an interview with the client to conduct the Social Summary and collect Medical Evidence (refer to IHCPPM 2412.10.00 and IHCPPM 2412.30.05) for the preparation of the medical packet to be sent to MRT for a determination of disability or blindness (refer to IHCPPM 2412.15.15 and IHCPPM 2412.50.00).

If a woman self-attests to being pregnant (refer to IHCPPM 2426.00.00), then eligibility may be considered under that category.

#### **Example**

A parent lives with her only child and receives MAGF. The child is seventeen and turns eighteen. The parent is no longer eligible to receive MAGF because she is no longer the caretaker of a dependent under 18. DFR notices that she previously claimed she was disabled but had never had disability determined by MRT or SSA. A Form FI 0017 is sent to the parent and prior to the deadline on that form, she contacts DFR and re-claims that she is disabled. DFR conducts the interview to complete Form 251B, Determination of Disability Social Summary, and the worker requests medical records in accordance with IHCPPM 2412.30.05. Unless medical records are not timely received due to a failure by the recipient, Medicaid will continue until MRT renders a determination that she does not meet the disability determination. If MRT determines that she is disabled and she meets all other criteria for MA D, her coverage under MAGF will be discontinued but she will then be granted MA D coverage.

#### **2236.00.00 REDUCTION IN SCOPE OF MEDICAID COVERAGE (MED)**

The following circumstances will result in the DFR taking action to reduce the scope of benefits. These are adverse actions requiring timely notice.

A recipient formerly eligible for full coverage becomes eligible for QMB-only, SLMB-only, or QI coverage;

A recipient eligible for full benefits loses eligibility for payment of nursing facility services or Home and Community-Based Services due to a violative transfer of property;

A recipient who was eligible for QMB-only coverage becomes eligible for SLMB-only coverage.

A recipient who was eligible for SLMB-only coverage becomes eligible for QI coverage.

A recipient who was receiving full coverage becomes eligible for Family Planning Services for Women and Men.

#### **2237.00.00 SUSPENSION OF MEDICAID BENEFITS (MED 1, 4)**

If a change in circumstances causes temporary financial ineligibility for MA, the AG may be suspended for up to two months. This can only be done in situations where it is reasonably certain that the recipient will again be eligible after the suspension. The typical situation in which this provision is applicable is in nursing home cases when the recipient accumulates excess resources. If there is a specified plan to spend the excess to the allowable limit without violating the transfer of property law, a suspension may be appropriate. If the recipient is eligible before the end of the suspension period, eligibility is to be reinstated without a reapplication. If after the suspension period the recipient remains ineligible, Medicaid must be discontinued. (Timely notice is required.)

#### **2237.05.00 SUSPENSION INCARCERATION/PSYCHIATRIC ADMISSION**

This provision is effective July 1, 2017.

When a recipient becomes incarcerated or is admitted to a psychiatric facility that results in ineligibility, the individual's health coverage is to be suspended, not discontinued.<sup>4</sup> The case action for either one of these circumstances is always to be suspension, regardless of the expected length of institutionalization. The suspension continues until the individual is released from the facility, but will not exceed 24 months. There is no limit on the number of times a recipient can be suspended. A single 24-month period will not be extended for any reason. The 24-month period begins on the first day of the month after institutionalization (or the following month if required to meet adverse action rules) and ends on the last day of the 24th month, at which time health coverage is discontinued if the individual remains institutionalized.

The suspension policy applies to all MED categories regardless of the age of the recipient.

Incarceration or psychiatric admission which will last for less than 30 days does not require an eligibility review.

Upon receiving notification that a recipient is institutionalized for at least 30 days, a review of the change in circumstances is required to determine whether the recipient remains eligible in the institution (in the case of a psychiatric admission) and what impact there is on other case members and other program eligibility. For children who enter juvenile detention facilities, correctional facilities for children, and secure facilities not licensed as child-care facilities, state law requires the juvenile court that adjudicated the delinquency to notify the DFR of the detention. This notification requirement was effective 7-1-09.<sup>5</sup>



During the period of suspension, case management activity such as redeterminations, processing data exchange updates, etc., will not occur when there are no other eligible recipients in the case. On the last day of the 24-month suspension period, the individual's eligibility status is systematically changed from suspended to closed.

#### **2237.10.00 REINSTATEMENT OF BENEFITS FOR SUSPENDED INDIVIDUALS**

Benefits for individuals who are in suspend status in accordance with Section 2237.05.00, are to be reinstated without a Reapplication if the individual returns to an eligible Living arrangement before the 24 month suspension period has expired, and the requirements of this Section are met.

Coverage for these members should start first of the month in the month the case is authorized. The DFR can use the Member or AR's self-attestation as verification of release from incarceration, unless questionable. In HIP cases the individual will be opened up in Basic, with a potential plus flag, regardless of whether they are below or above 100% of the FPL. The member will be given 60 days, from the date of authorization, to pay the PAC payment. If the PAC is not paid within the 60 days, members who are below 100% of the FPL will remain in Basic and members who are above 100% of the FPL will be closed. In the case of MA10 or MADW with a premium, the AG must be conditionally approved within the 40 days of release/discharge. Follow up verification of eligibility factors is required on reported information and discrepant information.

(MED 1, 2, & 4 only) If the former recipient returns to an active case, the existing redetermination month will apply to the recipient upon reinstatement. MADW cannot be reinstated unless current employment is verified.

If a progress report is due, MA D, MADW, or MA B cannot be reinstated until the MRT approves the continuation of disability.

If the individual returns to a case with no active members, the redetermination month will be systematically reset to 3 months in the future.

#### **2238.00.00 DISCONTINUANCE**

When an AG fails to meet the eligibility requirements of any category within a program, assistance is discontinued for that program. Discontinuance is effective the first day of the month following the expiration of the required timely notice.

#### **2238.05.00 DISCONTINUANCE DUE TO DEATH**

When a recipient dies, the living arrangement code on AEIDC is to be changed to "05" and the correct verified date of death is entered as the occur date. This action will invoke ED/BC and the AG can then be closed. This is crucial for Medicaid AGs because the fiscal contractor must have the correct date of death to ensure that claims will not be paid erroneously.

When an institutionalized recipient dies, the end date and delete code for death are entered on AEIII. This will bring up AEIDC where the living arrangement type of "05" and the date of death can then be entered.

It is important to allow ED/BC to run so that the individual is denied in ICES prior to deleting the individual. This ensures that the information is passed correctly to MMIS.

#### **2238.06.00 DISCONTINUANCE DUE TO WHEREABOUTS UNKNOWN**

When mail is returned as undeliverable with no forwarding address, efforts must be made to confirm the correct address, including checking documents in the case records, calling the individual at the phone number(s) on record, checking all available electronic resources and sending a 2032 address verification request to the last known address in the case record or to an authorized representative. Sending the pending request form may of course result in another returned mail, but it is an important step to ensure that the client is not discontinued inappropriately. If it becomes necessary to discontinue assistance because the client cannot be located and mail has been returned as undeliverable with no forwarding address, timely notice is required. If the client contacts the DFR before the effective date of the discontinuance and provides the new address, the discontinuance must be rescinded.<sup>6</sup>

#### **2238.10.00 CLOSED CASE FILES**

When all the AGs in a case are closed, the system will automatically transfer the case to closed files 90 days after the effective date of the discontinuance.

#### **2238.15.00 CERTIFICATES OF MEDICAID COVERAGE**

On August 21, 1996, The Health Insurance Portability and Accountability Act (HIPAA) were enacted. This law is designed to improve the availability of health insurance to working families and their children, including eligible individuals who have previous coverage under Medicaid. The provision of the law that directly affects the Division of Family and Children is the requirement concerning the issuance of certificates of creditable coverage. An individual, who enrolls in a health care plan that imposes an exclusionary period for a pre-existing medical condition, may be able to have that period reduced by prior coverage under another plan, including Medicaid. The DFR must issue the Certificate of Medicaid Coverage (FI Form 0021) to the individual so that he can present it as documentation to the new health insurance plan. Periods of Medicaid eligibility beginning July 1, 1996 for all full coverage categories and the pregnancy-related category, except as explained below, are included as creditable coverage:

Exclude QMB-Only, SLMB-Only, and QI coverage. Unlike the pregnancy-related categories, these categories do not provide coverage of regular Medicaid services.

Exclude months of ineligibility for which a recovery claim has been established and is currently in dispute through the administrative hearing process.

Exclude months the person did not meet spend-down.

The following procedures are to be used when issuing the certificate:

1. The ICES discontinuance notices for reasons other than death of the recipient contain the following paragraph which notifies the assistance groups that Certificates of Creditable Coverage are available upon request:

Important information about health insurance coverage. If you enroll in a health insurance plan that does not give you coverage for a preexisting medical condition, you may need to furnish proof of your Medicaid benefits. Ask the Plan Administrator of your health insurance about this. If you need proof of Medicaid eligibility, contact the caseworker whose name is on the first page of this notice and ask for a Certificate of Medicaid Coverage.

When it is necessary to issue a manual discontinuance notice (619M), workers must include the above paragraph in the additional information section of the notice. If the recipient's Medicaid coverage since 7-1-96 consisted solely of QMB only or SLMB only, it is not necessary to include the paragraph. However, if since that time, the person had full coverage or pregnancy-related coverage the paragraph must be entered on the notice.

2. Upon request by a former recipient, the FI Form 0021, Certificate of Medicaid Coverage, must be completed and mailed first class to the individual within 10 working days of the request. The DFR is encouraged to try to accommodate requests made in person by giving the certificate to the individual at the time of the request. However, if this is not possible, the aforementioned time frame should be met. When mailing the Certificate, the current address should be obtained from the individual rather than relying on the last address in ICES.

As an alternative to mailing a Certificate, it can be faxed directly to the health care plan administrator or the information can be provided by phone to the administrator only if the following conditions are met:

The individual requests it; and

The alternative method being requested by the individual is acceptable to the plan administrator.

If the two conditions are not met, the Certificate must be mailed to the individual.

3. As a general rule, one Certificate is completed per family. However, separate certificates are to be provided if requested. This could be needed if, for example, children are being enrolled in different insurance plans held by non-custodial parents.

4. Enter the name and address of the DFR and indicate the name and telephone number of a contact person in case the health insurance plan has any questions. This person can be the recipient's worker or anyone designated in the DFR to serve as coordinator for matters concerning the certificates.
5. Enter the name of each recipient in the family requesting the Certificate. Note that the Certificates do not necessarily have to correspond to the former assistance groups. For example, one AG may have been a child living with grandmother and the other AG in another case was the child's sibling and mother. When the certificate is requested, the mother and her 2 children are now living together. Unless there is a reason to issue separate certificates as requested by the family, or because there are too many eligibility periods, one certificate using all 3 recipients and their Medicaid coverage periods should be issued.
6. Enter the recipient's Medicaid number, i.e., the RID, not the case number.
7. List all creditable coverage periods after July 1, 1996 up to the present time without regard to category changes. For example, if a child was on MA 2 from 1/1/97 to 6/30/97 and MA D from 7/1/97 to 9/30/97, the entry on the certificate would be

BEGIN 1/1/97 END 9/30/97

Coverage prior to July 1, 1996 should not be listed. If an individual had coverage prior to July 1, 1996 enter the begin date on the certificate as July 1996. If the person is currently on Medicaid, enter "currently covered" in the end date box.

The statement on the Certificate which states that prior breaks in coverage may be included is information for health insurance companies only. The law specifies that certain coverage that has been interrupted cannot count as creditable coverage. The insurance company determines how creditable coverage is applied to an exclusionary period and the statement on the Certificate is simply to alert them to the fact that all coverage periods, regardless of breaks, are being reported on the form. The following are examples of how to enter eligibility periods on a Certificate:

**EXAMPLE 1**

Recipient was eligible from 10/96 through 11/97 with a spend-down. He met his spend-down in the months of 10/96, 12/96, 3/97, and 10/97. Entries on the Certificate should be listed as follows: BEGIN END 10/02/96 10/31/96 12/05/96 12/31/96 03/10/97 03/31/97 10/01/97 10/31/97 (Months that the spend-down is not met are not listed, and the DFR should inquire of HP what months spend-down was/was not met.)

Children under the age of 3 who are determined or redetermined eligible for any category of Medicaid will remain continuously eligible until their annual redetermination.<sup>[1]</sup> Medicaid coverage is to be retained for a full 12 months regardless of income or other factors that would otherwise cause the child to be discontinued. The CE period ends on the last day of the month in which redetermination is due.

There can be up to three consecutive CE periods. Category changes from full (Package A, Medicaid or HHW) to limited (Package C, MA 10) benefits are not allowed, and closure should only happen for these reasons:

- Death;
- Moved out of State;
- Written voluntary withdrawal;
- Failure to pay Package C premium.

When redetermining eligibility for a new 12 month period, CE protection is lifted and normal eligibility rules apply. If the child is no longer eligible, benefits can be denied at redetermination. If the child is still under 3 and is redetermined to be eligible, a new protected CE period begins. If the child turns 3 or the CE period ends prior to the scheduled redetermination, the case review occurs at redetermination.

**EXAMPLE 1**

In January an application is submitted for a baby who is 18 months old, and MA Z is authorized with three months of retroactive coverage. The CE period is set as January through December.

In June, income increases and MA 10 forms for the child. Because MA 10 is not equivalent coverage, a FIAT must be done to maintain the MA Z coverage until redetermination.

At the redetermination in December, MA 10 continues to form and can be authorized for the second CE period, which will start in January of the new year and continue until that December.

The child will have her 3<sup>rd</sup> birthday in the middle of her second CE period, but her coverage can continue until the scheduled redetermination in December.

Change reporting (other than a change of address) is not required for a child in a CE period. If a redetermination is done for other family members during the child's CE period, the family is not required to verify any income or assets belonging to the child as they pertain to the child's eligibility. If the family chooses to verify anyway, the following changes can be made:

The child can move from Package C to another medical assistance category;  
MA 10 premiums and Medicaid spend-downs can be decreased or increased.

While other category changes may occur during the CE period, a child covered under traditional Medicaid or Hoosier Healthwise Package A is not to be moved to Package C (MA 10) as this would entail the closure of Medicaid. Approval of Package C can only be permitted during the child's Medicaid redetermination.

**EXAMPLE 2**

A child is initially approved for MA 10 coverage. In month 4 of the CE period, his mother is due for a redetermination. Her Medicaid is closed for failing to provide updated income. Medicaid for the MA 10 child must be left open (as long as premiums are being paid), which may require a FIAT.

In month 6 of the child's CE period, the needed information to rescind the redetermination denial is provided and the income causes the child's premium to increase. Because he was already receiving MA 10 and this is not a category change, it can be authorized.

In month 8, the child's mother reports that she is getting fewer hours at work. The newly verified income causes his MA 10 to switch to MA 9. Because this is a beneficial category change, it can be authorized.

It should be noted that children are deemed eligible for coverage in MA X due to their mother's Medicaid status. Redeterminations are not set for this category; instead, eligibility under a new category of medical assistance must be determined when the child turns 1. Except for citizenship, the usual eligibility factors (including social security number) are to be verified. If found eligible, the child's first CE period would begin the month the new category is authorized.

**2238.25.00 REDETERMINATION 90-DAY EXTENSION FOR FAILURE TO VERIFY**

If an AG is discontinued for failing to verify required information during the re-determination process, the DFR must timely consider eligibility without requiring the AG to submit a new application when the missing verification(s), which were the reason(s) for discontinuance, are received by DFR within 90 days after the AG had eligibility effectively discontinued.<sup>7</sup>

If an AG is denied eligibility, this sub-section is inapplicable. If an AG is discontinued for failing to verify required information after a report of change has been received by DFR, this sub-section is inapplicable. If an AG is discontinued at point of redetermination for any reason(s) other than failing to verify required information, such as being over income, this subsection is inapplicable.

**2239.00.00 CORRECTION OF SPENDDOWN AND LIABILITY (MED 1)**

If an authorized spend-down or liability amount is lower than it should be (for example, client or hearing decision), recovery of any Medicaid overpayments must be pursued in accordance with the provisions in Chapter 4600.

However, in specific circumstances, authorized spend-down and liability amounts which are higher than they should be can be corrected to a lower amount by using screen CUMED. Acceptable reasons to use CUMED are as follows:

- Timely appeal filed after cut-off;

- Beneficial change timely reported and verified after cut-off;
- Agency error in calculation of spend-down or liability amount;

- Hearing decision decreased spend-down or liability amount;
- Court ordered decreased spend-down or liability amount.

No other reasons are acceptable in using CUMED. If a worker encounters a circumstance not listed above and feels the spend-down or liability correction should be made, the Policy Answer Line must be contacted.

When a change is made on CUMED for a given month, the "BNFT/S-L" field on IQAE for the eligibility segment containing that month, will be highlighted. This serves as an alert that at least one of the months in that eligibility segment has been changed via CUMED. AEBMB can be accessed to view the correct spend-down and/or liability amounts.

#### **2240.00.00 AG CHANGES ADDRESS**

Moving to a new address in Indiana, in and of itself, does not cause ineligibility. A new living situation may trigger new elements to be verified; however eligibility must not lapse while the systematic process of changing cases is completed.

#### **2250.00.00 VOLUNTARY WITHDRAWAL FROM ASSISTANCE**

A recipient may voluntarily withdraw from assistance at any time.

The withdrawal may be made in writing or verbally; however, if made verbally, a notice should be sent requesting confirmation. There should be a copy of the corroborating collateral request in the case file. Eligibility should not be discontinued if the written confirmation is not received.

A recipient voluntarily withdrawing from the HIP 2.0 program could be subject to a 6 month penalty period<sup>8</sup>, see IHCPPM 3555.15.00 for more information.

#### **2260.00.00 FOOTNOTES FOR CHAPTER 2200**

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<sup>1</sup> 42 CFR 435.916

<sup>2</sup> 42 CFR 435.916

<sup>3</sup> 42 CFR 431.213

<sup>4</sup> IC 12-15-1-20.4(a)

<sup>5</sup> IC 31-37-22-9

<sup>6</sup> 42 CFR 431.231

[<sup>1</sup>] IC 12-15-2-15.8

<sup>7</sup> 42 CFR 435.916(a)(3)(C)(iii)

<sup>8</sup> 405 IAC10-10-12