MEDICAL ASSISTANCE OVERVIEW

A-100 PURPOSE AND APPLICABILITY

The Medical Assistance Manual incorporates eligibility policy for all medical assistance programs including family medical groups, children's groups, specialized households, Nevada Check Up and Medical Assistance to Aged, Blind and Disabled (MAABD) groups.

Exceptions to medical assistance policies are noted in each chapter; otherwise the policy is applicable to all medical assistance programs.

A-105 MEDICAL ASSISTANCE OVERVIEW

The Affordable Care Act (ACA) requires all individuals to maintain minimal essential health coverage beginning January 1, 2014. Individuals who do not maintain minimal essential health coverage (MEHC) may face tax penalties for noncompliance. (MEHC) includes Medicaid, Medicare, government-sponsored programs, employer-sponsored health plans, and private insurance plans offered through a state's health insurance exchange.

Certain individuals may be excluded from the individual responsibility requirement. Individuals with religious objections, individuals not lawfully present in the U.S., and incarcerated individuals are excluded from the individual responsibility requirement. In addition, an exemption from the tax penalty is available for any individual who:

- Has coverage available that is considered cost prohibitive because their required contribution for coverage exceeds 9.5% of the annual household income;
- Has a household income of less than 100% of the Federal Poverty Level (FPL);
- Is a member of an Indian Tribe and eligible for services through an Indian health care provider;
- Has been without minimum essential coverage for less than three months; or
- Has obtained a hardship waiver from HHS because, for example, there is no affordable qualified health plan available to the individual through his or her employer or an exchange.

The ACA allows states to expand Medicaid to cover low-income adults and children with income up to 138% of the FPL. In addition, individuals and families who have income above the Medicaid level but below 400% of the FPL will receive tax credits to help them purchase coverage in the new health insurance exchange. People with income up to 250% of the FPL, receiving premium credits, will also get additional assistance with their cost-sharing charges.

States are required to coordinate eligibility across the different insurance affordability programs. The health reform law established new definitions of income – called Modified Adjusted Gross Income (MAGI) that is used in determining eligibility for advanced premium tax credits (APTC), Family Medical assistance and Nevada Check Up (NCU). Medical Assistance to the Aged, Blind and Disabled (MAABD) groups are exempt from the MAGI budgeting rules.

Individuals applying online will be evaluated for APTC, Medicaid and NCU and the electronic application will be referred to the appropriate agency based on the application information. Individuals determined ineligible due to excess income will be referred to the exchange for an APTC eligibility determination.

Medicaid and NCU eligibility determinations will be made using MAGI budgeting methodology to determine family size and household income. MAABD eligibility determinations use SSI budgeting methodology to determine family size and household income.

A–110 COOPERATION

All applicants and/or their authorized representative are required to furnish information and/or documentation necessary to establish initial and continuing eligibility in order to receive medical assistance. If a caregiver or household fails or refuses to cooperate with the Division of Welfare and Supportive Services (DWSS) district office, quality control, Investigations and Recovery or other designated DWSS officials in providing information which would impact pending or ongoing eligibility/benefits, the case will be denied or terminated.

In a noncooperation situation resulting in termination, allow applicable adverse action and provide legal notification.

A-115 PRIOR MEDICAL (435.915)

Prior medical assistance is available for up to three months prior to the application month. If the individual is requesting the coverage for prior months they must meet all eligibility requirements for that month.

A-115.1 Applying for Prior Medical Coverage

A request for prior medical assistance is considered a separate application because it is for months predating the initial application. Prior medical requests may be added during the pending period and during the 12-month period after approval, provided the case remains open. Approval, denial or pending of a prior medical request must always be addressed in a notice of decision to the household.

Prior medical assistance may be provided even if:

- The household is **not currently** eligible for Medicaid; or
- The person who received the medical care or services is deceased.

Do not delay an ongoing eligibility decision while obtaining information to determine prior medical eligibility. In addition, if the household is only requesting prior coverage, provide an ongoing eligibility decision at the time of the application.

If the individual is aged, blind or disabled and an SSI recipient determine if they would have been eligible for SSI had the Social Security Administration made a determination. This category of eligibility is used only after all other eligibility categories have been considered.

Do not make an independent SSI determination if there is a pending SSI application covering the month(s) Medicaid is requested. Use the Social Security Administration's SSI disability decision (the disability onset date) for any month of requested prior medical assistance. All other factors of eligibility, e.g., residency, citizenship, income, resources, etc., must be evaluated by the case manager.

Prior medical determinations must be made within 45 days from the application date for all categories except for disabled applicants which are given 90 days for processing.

Exceptions:

Nevada Check Up (NCU) applicants are eligible beginning the next administrative month after approval. Because these decisions are prospective, they are not eligible for prior medical coverage.

Qualified Medicare Beneficiary (QMB) applicants are eligible beginning the month immediately following the month the decision is made. Because these decisions are prospective, they are not eligible for prior medical coverage.

A-115.2 Verification of Prior Medical Assistance

The following are required for approval of prior medical assistance:

- Prior medical assistance must be requested; AND,
- Actual income (i.e.: paper or electronic documents, or telephone call to employer) for the prior medical month(s) being requested must be used; AND
- Citizenship documentation must be received prior to approval of prior medical months unless the eligibility evaluation is for the emergency medical services group.

A-120 AUTHORIZED REPRESENTATIVE (A/R)

Customers may designate anyone they choose to act on their behalf by completing the A/R section on the application, using the Authorized Representative Form 2525, **OR** they may complete and sign Form 2451 "Authorization for Release of Information" allowing the Division to release case information to individuals or agencies/organizations.

A Court Order of Guardianship or a valid Power of Attorney is acceptable as a designation of authorized representation. Power of Attorney status may vary with each customer. Obtain a completed Form 2525 for the individual case member designating the Power of Attorney as an authorized representative.

The authority to act as an A/R is valid until such time as the customer notifies the agency that the A/R is no longer authorized to act on his/her behalf, or the legal authority upon which their status was based has changed.

The A/R may also notify the Division that they no longer wish to be listed as an authorized representative for the customer.

The A/R must be:

- An adult, 18 years of age or older.
- Designated in writing with a valid signature by the customer or (if incapacitated) someone acting responsibly for the customer. This designation must include the name and address of the person chosen as an A/R, the signature of the household member making the choice, and the date.
- Willing to take responsibility for fulfilling all responsibilities encompassed within the scope of the authorized representation, to the same extent as the individual he/she represents.
- Able to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

  NOTE: Valid signatures from the customer or responsible person may be handwritten and submitted in person, via mail, or through commonly available electronic means (i.e. facsimile, email, internet website, etc…) accepted by DWSS. Electronic signatures made as part of a DWSS Access Nevada application, and telephonically recorded signatures are also acceptable.

If the designation is made by a household member who is unable to or cannot sign, their mark must be witnessed by someone other than the A/R.

With each subsequent reapplication, a new request, Form 2525 and/or Release of Information is required. It is not necessary at redetermination, unless the customer indicates a change of A/R.

When a public guardian is appointed to manage the affairs of an individual by Court Order, the Order of Guardianship is acceptable as a designation of authorized representation. Any deputy public guardian acting on behalf of the public guardian may contact the Division and request or give information to any DWSS case worker or customer service representative without being required to complete Form 2525 (Designation of Authorized Representative).

For Medical Assistance cases, all authorized representatives are considered a primary A/R. They receive all requests for information along with any attachments plus all notices. They hold the same responsibility as the customer in securing information for determining eligibility, reporting responsibilities and they are the only one authorized to sign on behalf of the customer. Primary representatives have the same access to case information as a customer. Legal guardians are always considered primary representatives. **There will be only one primary representative.**

NOTE: If an applicant lists an individual on the application as an A/R, they will automatically be entered as a primary representative.

Having more than one authorized representative (A/R) on a Medical Assistance case is allowable under certain circumstances. Customers who have the need for more than one A/R must select a single A/R as the primary A/R. Any additional A/R(s) must be entered as a Non-Primary authorized representative(s). Those who are a Non-Primary A/R(s) receive the same requests for information and notices as the customer but are not responsible for securing or reporting information; however, if they choose to, they may secure and report the requested information to the Division. A Non-primary A/R has the same access to case information as a customer, but cannot sign on behalf of the customer.

NOTE: If an applicant lists an organization or facility as an A/R on the application, they will automatically be entered as the primary representative unless another primary already exists. An individual representative of the organization or facility must be designated on the application. If a designated representative from the organization or facility is not listed on the application then obtain a completed form 2525.

Exception: Department of Health and Human Services (DHHS) divisions administering home and community-based waiver programs are automatically entered as secondary authorized representatives to ensure they receive all notifications and are able to assist customers in completing necessary paperwork. Form 2525 is not required for DHHS divisions. This exception includes but not limited to the following DHHS division/departments:

- Aging and Disability Services Division (ADSD)
- Department of Health Care and Finance Policy (DHCFP)
- Department of Public Behavioral Health (DPBH)
- Department of Child and Family Services (DCFS)

When applicants are unable to designate an A/R AND there are no family members or the existing family members do not wish to assist the applicant, the hospital, nursing home or county agency social service staff may designate themselves as an A/R.

The hospital, nursing home or county agency must make good faith efforts to contact family members of the applicant for information to help determine eligibility. The hospital, nursing home or county agency must provide the names and addresses of family members they contacted or tried to contact.

The case manager will send Form 2534 to the relatives advising them of the application, the hospital, nursing home or county agency representative and request any eligibility information to assist in processing the case.

NOTE: Division employees may serve as an A/R for a Medicaid case.

A-120.1 Spousal Authorization

A spouse whose income and resources are countable in determining a customer's financial eligibility, and is not applying for or receiving assistance, must sign an Interface Consent, Form 2179-EE, authorizing DWSS to interface with other federal and state agencies for information and verifications.

A-125 MEDICAID CARD ISSUANCE AND RESTRICTED STATUS

All newly approved Medicaid recipients are issued a permanent plastic Medicaid card. When a household reports non-receipt of their Medicaid card, verify the customer mailing address in AMPS and issue a new Medicaid card for the reported household member(s).

A new Medicaid card is automatically issued if the customer's name, date of birth or gender are changed and/or updated. A new card is NOT automatically issued when the address is changed.

Households where the use of the Medicaid card is questionable may have their card stamped with a restrictive endorsement.

A-130 MANAGED CARE ENROLLMENT

Through the Division of Health Care Financing and Policy (DHCFP), Nevada Medicaid and Nevada Check Up operates both a fee-for-service (FFS) and a managed care reimbursement and service delivery system to provide covered medically necessary services to its eligible populations. Managed care is a method of payment and a care delivery model that allows providers to bill the managed care organization. FFS is a payment model that allows the medical provider or facility to bill the DHCFP's fiscal agent directly.

Managed care enrollment is only available for MAGI based medical groups for recipients in the urban areas of Washoe County and Clark County. Certain medical groups are voluntary enrollment in Managed Care Organization (MCO), such as Native Americans, children with special health care needs enrolled in a Title V program, and severely emotionally disturbed (SED) children Aged, blind and disabled populations, the Medicare eligible population and those receiving SSI benefits are not eligible for managed care.

Initial enrollment in managed care is processed based on the customer's choice at application (this does not guarantee enrollment into their plan of choice). Individuals applying online will be given the choice online and the managed care choice should be entered into the "Other Application Information" on the Case Info Bap in AMPS or APPL screen in NOMADS when processing paper, telephonic, and virtual applications. Households must choose one managed care plan for all eligible household members.

If a household fails to choose a managed care plan the case manager must select the "No MCO Selected" option from the MCO drop down in the MCO field and DHCFP will randomly assign them to one of the MCO's.

Renewals submitted less than 60 days after the loss of coverage will keep the same MCO preference or the random assignment as the previous application.

Renewals submitted more than 60 days after the loss of coverage must include a new MCO preference selection.

All recipients will be allowed the opportunity once a year, during Medicaid Managed Care open enrollment, to change MCO's. Open Enrollment is October 1st through October 31st. When a request is made to change MCO, the recipient must write to Nevada Medicaid or email (preferred method) to NevadaManagedCareOpenEnrollment@gainwelltechnologies.com to change their MCO. The request must include:

- their billing number;
- what MCO they want to change to; and
- signature and date of the request.

Requests are mailed to:

Nevada Medicaid
PO Box 30042
Reno, NV 89520

Recipients will have 90 days from the effective date to make one (1) final MCO change. Once this final change has been processed, the household will remain in the selected MCO until the next open enrollment period. Please direct recipient to:

https://dhcfp.nv.gov/members/blu/mco_open_enrollment/

NOTE: Recipients may submit an MCO change when they are not within their 90-day window, due to good cause. For good cause eligibility criteria, please direct recipient to:

https://dhcfp.nv.gov/Members/BLU/MCO_Good_Cause_Disenrollment/

A-135 SERVICES PROVIDED BY NEVADA MEDICAID

Refer to the Division of Health Care Financing and Policy (DHCFP) website for information on services provided by Nevada Medicaid. DHCFP (nv.gov)

NOTE: Refer recipients to local district Medicaid office staff if more detailed Medicaid service information is needed.

A-140 MEDICAID ESTATE RECOVERY PROGRAM

A-140.1 Legal Authority

Authority for operating the Medicaid Estate Recovery (MER) Program is published in Section 1917 of the Social Security Act and Nevada Revised Statute 422.29302.

A-140.2 Program Overview

Federal and state law mandates state operation of a MER program whereby correctly paid Medicaid benefits are recoverable from the estate of a deceased Medicaid recipient. Recovery is accomplished only after the death of a recipient and at a time when there is no surviving spouse, children under the age of 21 or adult disabled children.

Regulations of the MER program affect individuals who received Medicaid benefits on or after October 1, 1993. Collections will be pursued against the estate of the recipient up to the amount of Medicaid benefits correctly paid or up to the determined value of the recipient's estate, whichever is less.

The MER program is administered by DHCFP.

A-140.3 Affected Individuals

MER actions are imposed against Medicaid recipients who are:

- 55 years of age or older when they receive Medicaid assistance; or
- an inpatient in a nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or other medical institution, where they are required to pay patient liability for medical care.

A-140.4 Notification to Affected Individuals

Full disclosure of MER program operation is made during the application process. Statements regarding MER are included on the eligibility application and applicants (or their representatives) are provided Form NMO-6160-E, "Medicaid Estate Recovery Notification of Program Operation." Staff **MUST** attempt to review information provided on Form NMO-6160-E-with the customer. However, if staff is unable to review information provided on Form NMO-6160-E with the applicant (or their representative) will NOT preclude DWSS's pursuit of correctly paid benefits.

Form NMO-6160-E, Medicaid Estate Recovery Notification of Program Operation, must be given to all applicants for Medicaid assistance at the time of application for services and redetermination. Be sure the applicant receives the form in English or Spanish, whichever is appropriate.

One copy of the form will be given to the applicant and one copy will be filed in DIS.

NOTE: Medicare Savings Program (MSP) applicants were excluded from MER effective January 1, 2010.

A-145 REFERRAL OF CASES TO MER UNIT

When a MER-applicable recipient is no longer Medicaid eligible due to death, the case manager MUST forward the case file to the Division of Health Care Financing and Policy (DHCFP) by taking the following actions:

1. If the case is virtual-only (AMPS), immediately notify MER via email at MER@dhcfp.nv.govThe email must contain the recipient's name, Medicaid billing number, and SSN or UPI.

2. If there is a physical case file, the case manager MUST forward the file to DHCFP via interoffice mail, Attention: MER, within three (3) working days after the closure of the Medicaid CASE.

NOTE: DHCFP also has access to view records in DIS. Therefore, only those records currently maintained outside of DIS by specialized units will need to be forwarded to the MER unit.

If the return of a paper case file is necessary, eligibility staff must request in writing the return of the case file. The written request must include the name and SSN of the recipient, the date of the request, the eligibility staff member requesting the file, and the district office where the file should be sent. The request may be faxed or forwarded to DHCFP, Attention; MER utilizing interoffice mail. MER staff will provide the case file within three (3) working days.

Case files for Medicaid applicants who have been denied Medicaid eligibility and who do not have a history of prior approval should not be forwarded to the MER unit at DHCFP.

A-145.1 INITIATION OF MER ACTIVITIES

Upon receipt of the closed Medicaid eligibility casefile, DHCFP MER personnel will establish a MER recovery case. MER staff will validate the recipient's reported resource information.