REDETERMINATIONS

D-400 MAGI REDETERMINATIONS (435.916)

Redeterminations for MAGI medical assistance groups must:

a. have eligibility renewed once every 12 months; **and**

b. be completed without requiring information from the individual when all information needed to redetermine eligibility is available via electronic data sources; **or**

c. When data sources are unavailable, a pre-populated Redetermination Form 2006-EM is mailed to the recipient and if applicable the AR, at least 60 days prior to the redetermination date. Request the client to provide any required verifications **and** to sign and return the form within 30 days.

Evaluate eligibility under **all** medical assistance programs when processing a redetermination.

If a signed redetermination and requested verifications are not returned, medical assistance may terminate, allowing adverse.

Note: D-400.2 contains specific guidance in verifications due at redetermination.

If an unsigned redetermination is received without the Head of Household's, or AR's signature, the case manager should attempt to contact the Head of Household or AR to obtain a verbal signature over the telephone. If the case manager is unable to reach the Head of Household or AR, terminate the case allowing adverse.

If the individual subsequently submits the signed renewal within 90 days after the termination notice date, use the RD in lieu of a new application to evaluate ongoing eligibility. Prior medical may be evaluated if requested during the 90 day grace period. After the 90 day grace period a new application is required.

A medical redetermination may be completed between regular renewals any time DWSS receives information about a change in circumstances that may affect eligibility. See D-440 for more information.

D-400.1 Reserved

D-400.2 Verification At Redetermination

Verify the following eligibility factors at redetermination:

- **Income:**
  - If the individual returns verification of income and a 30/60 day best estimate of their pay history accurately reflects their current circumstances, consider the income verified and continue case processing.

- If the individual has an open TANF or SNAP case with verified income information and this verification reflects their current circumstances, consider the income verified and continue with case processing.

Note: If the individual does not provide their paystubs, and the information cannot be obtained via an electronic data source, pend the client allowing 10-days to return the necessary verifications. Do not automatically terminate the case for non-cooperation.

- **Tax filing status/Household –** accept client statement
- **Authorized representative changes** -Assume there is no change in the status of the A/R for the client unless they report a change.
- **Residency** – accept client statement

D-410 MAABD REDETERMINATIONS

Redeterminations for MAABD medical assistance groups must:

a. have eligibility renewed once every 12 months; **and**

b. be completed without requiring information from the individual when all information needed to redetermine eligibility is available via electronic data sources; **or**

c. When data sources are unavailable, the MAABD Only Redetermination, Form 2930-EM, is mailed to the recipient and if applicable the AR, at least 60 days prior to the redetermination date. Request the client to provide any required verifications **and** to sign and return the verifications and form within 30 days.

d. Process the redetermination no later than the month it is due, ensuring the correct aid codes, eligibility codes, Medicare claim numbers and buy-in are correct in the system.

Evaluate eligibility under **all** medical assistance programs when processing a redetermination.

If a signed redetermination and requested verifications are not returned, medical assistance may terminate, allowing adverse.

Note: D-410.1 contains specific guidance in verifications due at redetermination.

If an unsigned redetermination is received without the Head of Household's, or AR's signature, the case manager should attempt to contact the Head of Household or AR to obtain a verbal signature over the telephone. If the case manager is unable to reach the Head of Household or AR, terminate the case allowing adverse.

If the individual subsequently submits the signed renewal within 90 days after the termination notice date, use the RD form in lieu of a new application to evaluate ongoing eligibility. Prior medical may be evaluated if requested during the 90 day grace period. After the 90 day grace period a new application is required.

A medical redetermination may be completed between regular renewals any time DWSS receives information about a change in circumstances that may affect eligibility. See D-440 for more information.

D-410.1 Verification at Redetermination

Verify the following eligibility factors at redetermination:

- **SSI Recipients –** Verify receipt of SSI as a Nevada resident using SOLQ or any other available electronic data source. Complete the redetermination without requesting any further information from the client.
- **Income:**
  - If the individual returns verification of income and a 30/60 day best estimate of their pay history accurately reflects their current circumstances, consider the income verified and continue case processing.
  - If the individual has an open TANF or SNAP case with verified income information and this verification reflects their current circumstances, consider the income verified and continue with case processing.

  Note: If the individual does not provide their paystubs, and the information cannot be obtained via an electronic data source, pend the client allowing 10-days to return the necessary verifications. Do not automatically terminate the case for non-cooperation.
- **Resources**
- **Expenses –** verify monthly expenses used in the patient liability calculation. If not provided calculate patient liability without the expenses.
- **Authorized representative changes** - Assume there is no change in the status of the A/R for the client unless they report a change.
- **Residency** – accept client statement

Do not re-verify:

- **Disability** - unless Nevada Medicaid Office determines that a beneficiary's disability no longer meets the definition of disability or SOLQ indicates disability has ended.

- **Blindness -** unless a physician determines that a beneficiary's vision has improved beyond the definition of blindness or SOLQ indicates blindness has ended.

D-410.2 Public Laws

Verification used to support the Public Law status must remain in the permanent section of the case file.

Pickle Amendment – Public Law 94–566 CASES - Income & resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Exclude from countable income RSDI cost of living increases received after client was last eligible for and receiving SSI and entitled to RSDI in the same month.

Adult Disabled Child – Public Law 99–643 CASES - Income and resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Exclude from countable income the 'adult disabled child' benefit OR the increase in their 'adult disabled child' benefit received after July 1, 1987.

Widow/Widowers – Public Law 100–203 CASES - Income and resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Exclude from countable income widow/widower's benefits and SSA retirement/survivors benefits (SSA Dis¬ability benefits are not disregarded). They cannot be entitled to Medicare Part A hospital insurance.

Widow, Widowers and Surviving Divorced Spouses – Public Law 101–508 CASES - Income and resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Exclude from countable income the Title II disability benefits. They cannot be entitled to Medicare Part A hospital insurance.

Suspension of SSI Due to Income – Public Law 96–265 CASES - The most current SDX must contain Public Law Code "I". If it does not, the client is not eligible for Medicaid under this public law.

Social security Independence and Program Improvements Act of 1994 – Public Law 103-296 CASES - The most current SDX must contain Public Law Code "A". If it does not, the client is not eligible for Medicaid under this public law.

Sponsor Deeming Cases - Income and resources are re-evaluated. Financial eligibility is determined using SSI Budget Form 2646. Disability for persons under age 65 may need re-evaluation by NMO (see most recent Form 3004). Parent and spouse deeming requirements may apply. Determine any contributions by the sponsor(s). Case file should have an indicator when sponsor deeming ends for a referral to apply for SSI.

D-420 TITLE IV-E ELIGIBLE FOSTER CHILDREN AT RITE OF PASSAGE

A Medicaid redetermination (RD) must be timed to coincide with the Title IV-E eligibility review. The custodial state must provide the IV-E RD date prior to approval, and the Medicaid RD due date should be adjusted in the system at approval to ensure the case comes up for review at the appropriate time.

D-420.1 Verification at Redetermination

- Request a new application
- Written verification from the custodial state regarding continued IV-E eligibility.

Continue medical assistance if all eligibility criteria continues to be met.

D-420.2 Termination of Foster Children at Rite of Passage

Terminate assistance allowing adverse action if:

a. Rite of Passage fails to provide the information needed to complete the RD process, and/or

b. the recipient no longer meets the eligibility criteria for this category of assistance.

D-425 AGED OUT OF FOSTER CARE

A redetermination is to be completed every 12 months.

D-425.1 Verification at Redetermination

- Residency is the **only** required verification at RD.

D-425.2 Termination of Aged Out of Foster Care

Medicaid must be terminated, allowing adverse action when:

a. the recipient reaches age 21, *if* the child was not enrolled in Nevada Medicaid at the time of aging out of foster care; or

b. the recipient reaches age 26; or

c. moves to another state; or

d. is placed/lives in an ineligible facility (jail/detention).

Note: Closure of an Aged Out of Foster Care case is done at the individual member level. The AO Closure reason codes are located on the individual's MEMB screen.

D-430 TREATMENT FOR BREAST AND CERVICAL

A redetermination is to be completed every 12 months. Complete a desk audit by contacting Access to Health Care case manager to confirm the recipient is still residing in Nevada and is still receiving treatment.

Access to HealthCare Network can be reached at 775-284-1904.

Document the information in the case file and complete the redetermination.

D-430.1 Termination of Breast and Cervical

Medicaid eligibility ends when her course of treatment is completed, or she no longer meets the criteria for this eligibility category.

D-435 TRANSITIONAL MEDICAID

A redetermination will be completed to determine potential eligibility for other medical coverage groups after the end of the TR period. Evaluate current circumstances and all household members for any other category of eligibility.

D-440 REDETERMINATION BASED ON CHANGES

Information received between redeterminations, which may affect eligibility must be evaluated and acted on when applicable. Limit any request for additional information to verification related to the change only.

When processing the change if the case manager has enough information available to re-evaluate eligibility, complete a redetermination and approve an additional 12 months, even if the redetermination was not due.

Exception: Nevada Check Up provides 12 months continuous eligibility and clients are not required to report changes. Only act on changes listed in D-535 for Nevada Check-Up.

D-445 OTHER INSURANCE AFFORDABILITY PROGRAMS

When processing a redetermination and the recipient is determined not eligible due to excess income an electronic referral is sent to the Silver State Health Insurance Exchange (SSHIX) upon posting of the denial. The individual will be provided contact information in their denial notice regarding where to apply for Advanced Premium Tax Credit (APTC) and Qualified Health Plans (QHP).

D-450 TERMINATIONS

When processing a redetermination and the recipient no longer meets the criteria of one of the eligible categories or has failed to cooperate in providing information, the case must be terminated allowing for adverse action. When posting a termination, two future months must be posted in order to ensure closure in the MMIS system. Adverse actions taken after cutoff will not be reflected in the MMIS (Medicaid billing) system. If done, an additional month of Medicaid billing will take place and capitation fees will be charged.