CHANGES

D-500 OVERVIEW

Changes are situations that occur in a household which may affect eligibility. Action must be taken on **reported** changes, regardless of the client's reporting requirements, to ensure program integrity is maintained.

D-505 REPORTING REQUIREMENTS

Households are advised of their responsibility to report changes in:

- Income (earned and unearned);
- Household composition/household member's extended absence;
- Marital status;
- Residence or mailing address;
- Medical insurance coverage;
- Other circumstances or anticipated changes which may affect eligibility;
- Social Security number for a required household member.

MAABD Exception: In addition to the above reporting requirements, MAABD households are required to report changes in resources.

D-510 WHEN TO REPORT

Changes must be reported immediately from the date of application up to the date of approval.

After approval, any change in circumstances must be reported no later than the **fifth** of the month following the month the change occurred.

MAABD Exception: After approval, any change in circumstances must be reported no later than the **tenth** of the month following the month the change occurred.

D-515 HOW TO REPORT

Household members or someone acting on their behalf may report changes:

- in person;
- by telephone;
- by mail, fax or email;
- on the Change Report Form 2584; and
- changes received by Nevada Health Link will be received as a task in AMPS.

Applications submitted to the Division are another method of reporting changes. Each application should be evaluated for changes that would affect ongoing benefits, such as a member moving out of one household into another.

D-520 QUESTIONABLE INFORMATION AND/OR UNREPORTED CHANGES

If a household has circumstances that are questionable due to a reported change, third party information, or because the household fails to report a change (i.e. birth of a child, critical age change, obtains insurance from a job, etc.), take the following steps:

a. Contact the household to obtain an explanation for factors of eligibility that allow client statement.

b. Send a request for information using Form 2429–EE when clarification and/or verification are required to determine continuing eligibility.

c. Allow the household at least 10 days to respond to the request for information, clarification and/or verification.

   Exception: Victims of domestic violence approved for fictitious address through the Secretary of State's CAP program must be allowed 17 days to provide verifications due to mail forwarding. Follow adverse action and processing time frames.

d. If the household fails to respond or does not provide enough information to continue the case, resulting in a reduction or termination of benefits, a Notice of Decision **must** be mailed at least 13 days prior to the effective date of the reduction/termination.

If a third party (other than the authorized representative) does not cooperate in providing information or provides incomplete information, DO NOT close the case. Work with the client and information already on file (includes income) to arrive at a prudent decision or resolution based on the best information available. Document the circumstances in the CLOG.

D-525 PROCESSING REQUIREMENTS

Update the mailing address as soon as a change is reported. If a reported change of address is not updated by cut-off, the Notice of Decision (NOD) and/or Medicaid card will be mailed to the old address. The NOD and Medicaid card will also be returned if the address is not updated.

D-525.1 Returned Mail

If mail is returned by the U.S. Post Office with **an out-of-state forwarding address or no forwarding address;** ensure the out-of-state address is updated on the case prior to posting and close the case waiving adverse action.

D-525.2 Actions on Changes

Upon receipt of a change, ensure the following actions are completed:

1. Check the system to identify all related cases affected by the change.
2. Review the change to determine the effect on the household's benefits.

   a. If the change results in additional members becoming eligible, verification must be obtained prior to taking action on the case. If verification is not received within the allotted time frames, deny the request for the additional member(s).

   b. If the change results in members becoming ineligible, act on the change and reduce or terminate benefits, allowing adverse action.

      - Verification is not needed if entire household becomes ineligible; use client statement and update the case.
      - Request verification only if at least one member remains eligible.

   c. If the reported change in income does not change the current eligibility of any members, do not request verification, use client statement.

   Example: Pregnant mother and one child in the household. Monthly income of $1,000.00 is being budgeted and mother calls to report her income is reduced to $800.00 monthly. The new income amount does not change the medical eligibility for any household members. Therefore, update the income based on client statement and do not require verification for the medical programs.

3. Evaluate all electronic verification sources available, prior to requesting verification from the client. Do not request verification of non-taxable income for MAGI cases.

   a. If no electronic data source is available, request verification required to update the case based on the reported change. Allow 10 calendar days from the mailing date for the client/representative to provide requested information.

   b. When requested verifications are not provided, terminate assistance allowing for adverse action. If verifications are provided on or before the effective date of closure, reinstate assistance.

4. Document

   – the reported change;
   – the date the change occurred; and
   – the date the change was reported; and
   – the actions taken on the case.

5. Re-evaluate eligibility for all medical programs and update the case. If all necessary information is available to complete a redetermination, process the RD and approve an additional 12 months
6. Notify the household of the action taken.

D-525.3 Mass Changes

The state or federal government initiates changes which affect all or a large number of households. Reporting these changes is not required. Mass changes generally occur in:

- the income eligibility standards;
- cost-of-living adjustments (COLA) for Social Security, SSI, VA, and other federal benefits; and
- other eligibility criteria based on legislative or regulatory actions.

Generally, individual notices are produced for automated mass changes whenever a change in the benefit amount occurs.

D-525.4 Additions to the Household

Re-determine eligibility when a new member must be added; **If:**

- the new member is active in another household, do not add them until they are removed from the other household.
- a new member of the tax filing unit is not reported timely and the change results in a decrease in eligibility, the case is updated the following month, allowing adverse action.
- a new member is requesting coverage and the change results in an increase in eligibility, the case is updated the month in which it is reported by the assistance unit.
- information or verification needed to add a household member is not provided by the date requested, terminate assistance.
- a newborn is reported and all eligibility requirements are met, add them to the assistance unit effective their date of birth. Use the most readily available verification to add the child to the medical case. **Example:** Client statement, hospital discharge forms, managed care alert, birth confirmation.

  Newborns are eligible for Medicaid for one year without a separate application when the mother was eligible for Medicaid at the time of the birth.

D-525.4.1 Exceptions for Adding Newborns to NCU Cases

- A newborn will be retro enrolled in Nevada Check Up if the following criterion is met:
  - The agency is notified within 14 days from the date of birth (the first day begins the day after the date of birth).

  If the notification criterion is not met, the newborn will be enrolled the next administrative month following notification if deemed eligible.

Exception: if the mother has other health insurance that provides 30 days of coverage for the newborn, the newborn will be enrolled as of the first day of the next administrative month following the date of birth. Upon notification of birth, NCU will confirm that the newborn does not have other insurance coverage prior to enrollment.

- A newborn cannot be enrolled prior to a family's start date.
- A newborn may be enrolled without a Social Security Number (SSN); however, an SSN will be required by the child's first birthday.

D-525.4.2 NCU Enrollment

Once determined to be eligible for NCU, a child(ren) will be enrolled beginning the next administrative month.

D-530 TERMINATIONS FOR MEDICAID

Prospectively determine ongoing medical assistance using the policy in effect for the future month.

When a recipient can no longer meet the requirements of one of the eligible categories or has failed to cooperate in providing information, the case must be closed. When posting a termination, two future months must be posted in order to ensure closure in the MMIS system.

Note: Regardless of changes in income, pregnant women remain eligible through the post-partum period and Nevada Check Up eligible children remain eligible through the 12 month eligibility period.

If the client cooperates prior to the effective date of termination, reinstate the case and evaluate medical eligibility.

D-530.1 Non-Payment of Nevada Check Up Premiums

When a household is 60 days, or two full months past due, the case will be terminated. A non-payment of premium task will be created in AMPS and must be acted on for the future month. Case workers will be notified with a task in the system when non-payment has occurred.

Once a termination for non-payment of premium has occurred, the household must serve a 90 day sit-out period. If payment is received within the 90 days, DHCFP will notify DWSS, and the child/ren will be enrolled beginning the next administrative month. If payment is received after the 90 day period, a new application is required.

If all other eligibility criteria is met and the 90 day sit-out has been served, a child/ren cannot be denied eligibility, even if a past due balance exists. The chil d/ren will be enrolled and any outstanding debt will be managed by DHCFP.

D-530.2 Adverse Action

When assistance is terminated, a Notice of Decision (NOD) must be sent to both the client and the representative/legal guardian a minimum of 13 days before the proposed action is effective. In order to meet the 13 day time frame, cases must be posted at least 14 days prior to the end of the month. Send a NOD to the authorized representative of the deceased person.

The following is a chart showing the adverse action dates for 2017.

Month	Adverse Action
January	1/18/17
February	2/15/17
March	3/16/17
April	4/17/17
May	5/8/17
June	6/15/17
July	7/18/17
August	8/17/17
September	9/15/17
October	10/18/17
November	11/16/17
December	12/18/17

D-530.3 Adverse Action NOT Required

Adverse action may be waived in certain circumstances, however **cannot** be waived after cutoff.

The case manager may waive adverse action if:

- The case manager has factual information confirming the death of a recipient;
- The case manager receives a clear written statement signed by a recipient that:
  1. They no longer wish to have services; or
  2. Gives information that requires termination or reduction of services and indicates they understand this must be the result of supplying that information;
- The recipient has been admitted to an institution where he/she is ineligible under the plan for further services;
- The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address;
- The case manager verifies the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

- A change in the level of medical care is prescribed by the recipient's physician;
- Nevada Check Up child obtains other creditable health insurance coverage.
- Non-citizenship status is verified.

D-530.4 Cut-Off

Medicaid actions that **do not** adversely affect benefits, such as a change in aid code, can be taken up to the second to the last work day of the month. Adverse actions taken after cutoff will not be reflected in the MMIS (Medicaid billing) system. An additional month of Medicaid billing will take place and capitation fees will be charged when termination is posted after cutoff for the following month.

The following is a chart showing the cut-off dates for 2017.

Month	Cut-Off
January	1/20/17
February	2/17/17
March	3/24/17
April	4/21/17
May	5/26/17
June	6/23/17
July	7/21/17
August	8/25/17
September	9/22/17
October	10/20/17
November	11/22/17
December	12/22/17

D-535 RE-EVALUATIONS - NEVADA CHECK UP

a. Cases will only be re-evaluated at the time of RD unless one of the following occur:

- NCU discovers or is notified that the information used to enroll a child/ren was incomplete or inaccurate;
- The participant requests to add a child (child/ren currently enrolled will remain enrolled until the time of RD).
- The participant requests a reduction in premium when household income has changed (child/ren will remain enrolled until the time of RD).

b. Re-evaluations must be processed before the corresponding cut-off but not to exceed 30 days.

D-540 CONVERSIONS

During a period of eligibility, there may be changes in case circumstances where another category of eligibility must be evaluated. Converting between categories does not require a new application, but may require additional forms to be completed or information to be gathered by the case manager. When converting to an *equivalent* category, i.e., home based waiver to institutional, do not request additional information unless a change in income or resources is reported.

When converting a case to a new aid code, ensure the action is taken prior to cut-off. Actions taken after cut-off for the next month do not update in the MMIS system.

The following types of conversions identify procedures required to re-evaluate factors of eligibility.

Expanded eligibility under the new adult group (AM1 and CA) is an optional group which must be considered only after all mandatory groups are evaluated. When a recipient is eligible under this group and they become institutionalized, they must be evaluated under the institutional group; if not eligible under institutional, they can remain eligible under AM1 or CA.

Exception: Use the following steps when converting a Nevada Check-Up (NCU) case to another Family Medical aid code or to a MAABD program:

1- Nevada Check-up to Family Medical

a. Initiate a REHA in the appropriate footer month based on the reported change. The REHA action will instruct the system to evaluate all family medical programs for each individual in the household.

b. The conversion of eligibility is effective the first administrative month after the month in which the action was taken. An administrative month requires all case actions be completed prior to cut-off. If the REHA action is done after cut-off, allow the change in eligibility to take effect in the next administrative month.

(Example 1) REHA 05/15/2015, change effective 6/01/2015.
(Example 2) REHA 05/29/2015, change effective 7/01/2015.

2- Nevada Check-up to SSI Case

a. Verify SSI eligibility. Create a sub-case if SSI recipient is not head of household, or if others in household have Medicaid.

b. Terminate eligibility under current category prior to cut-off and approve SSI eligibility for the following month. View and post a corrected version to update the aid code and eligibility code and then notify the client of the change in benefits.

c. Evaluate for parental financial obligation for children under 18 if there is no deeming of parental income/resources in determining eligibility.

3- Requesting a Refund of Premiums

a. If after case processing the household is determined eligible for a new family medical aid code or a new MAABD subcase has been created, a refund may be requested from DHCFP for any future months in which NCU premiums have already been paid by the household. Only months that were converted from NCU to another aid code/program can be included in this request.

b. DWSS staff should email the NCU Specialist with case information regarding any refund to the household. The NCU Specialist will review each case and forward the information to DHCFP as necessary.

D-540.1 Converting to Institutional Eligibility

Do not terminate eligibility for individuals currently eligible under another medical group while institutional eligibility is being evaluated if they continue to meet eligibility criteria.

a. Evaluate current resources and compare to institutional resource limit. When the applicant is married (living separate or together), request the couples' current resources and complete a spousal resource assessment.

   Note: This step is not necessary when converting from home based waiver category unless a change in resources is reported.

b. Evaluate current income. Do not request verification unless a change in income due to institutionalization occurs. Complete a spousal impoverishment determination if a community spouse is involved. If recipient is SSI eligible and payment has not been reduced to the $30.00 institutional level, notify Social Security using form 3911.

c. Ensure the medical facility is added as an authorized representative (use category 4 if not signed on as primary or secondary by applicant).

d. Evaluate case for transfer of resources when converting from any category other than home based waiver.

e. Evaluate court orders and income trusts if applicable.

f. Evaluate for other possible benefits; veterans or widows of veterans may be eligible for Aid and Attendance or have VA insurance benefits. The pension of a veteran residing in a Nevada State Veteran's home is not reduced to $90.

g. Complete a redetermination if all required factors of eligibility are available and verified.

h. Update the appropriate screens in the system, view and post versions to update to appropriate aid and eligibility code. Allow adverse action for any reduction in benefits, including QMB.

Note: Clients have multiple GRIN screens when they enter/leave different facilities. One screen should be entered for each facility stay.

i. Notify the client and authorized representative of the change in benefits and patient liability amount. Add free form text to ensure a notice is generated.

j. Evaluate for parental financial obligation for children under 18.

D-540.2 Converting to Home Based Waiver Eligibility

a. Ensure Form 2734 authorizing home based services is completed, and that if the client is under age 65, there is a current disability decision by SSA or DHCFP through Form 3004.

b. Evaluate current resources and compare to institutional resource limit. When the applicant is married (living separate or together), request the couples' current resources and complete a spousal resource assessment.

Note: This step is not necessary when converting from institutional > 30days unless a change in resources is reported.

c. Evaluate current income; do not request verification unless a change in income occurs.

d. Ensure the appropriate agency is added as an authorized representative.

e. Evaluate case for transfer of resources when converting from any category other than institutional >30 days.

f. Evaluate court orders and income trusts if applicable.

g. Complete a redetermination if all required factors of eligibility are available and verified.

h. Update the appropriate screens in the system, view and post versions to update appropriate aid and eligibility code.

i. Notify the client and authorized representative of the change in benefits. Allow adverse action for any reduction in benefits, including QMB. Add free form text to ensure a notice is generated.

j. Evaluate for parental financial obligation for children under 18 if there is no deeming of parental income/resources in determining eligibility.

Note: When a client is converting from Institutional to a Home and Community Based Waiver in the middle of a month, post the HBW aid code for the waiver approval month. The GRIN screen must be completed with the date they leave the facility to allow Medicaid to pay the facility bills as well as provide Home based services in the same month. Complete Form 2817, Partial Month, to advise DHCFP of the partial institutional month.

D-540.3 Other MAGI Groups to SSI Case

a. Verify SSI eligibility. Create a sub-case if SSI recipient is not head of household, or if others in household have Medicaid.

b. Terminate eligibility under current category prior to cut-off and approve SSI eligibility for the following month. View and post a correct version to update the aid code, eligibility code and notify the client of the change in benefits.

c. Evaluate for parental financial obligation for children under 18 if there is no deeming of parental income/resources in determining eligibility.

D-540.4 SSI Eligibility Terminating

a. When SSI eligibility terminates, evaluate each Public Law category. Update the appropriate information/STAT screens in NOMADS, view and post a correct version to update the aid code, eligibility code, and to notify the client of the change in benefits.

b. Evaluate eligibility for Medicare beneficiary programs.

c. If Public Law criteria are not met and the recipient is a disabled child under age 18, terminate eligibility allowing 13 days adverse action time. Evaluate eligibility under the Child group and Nevada Check Up; if not eligible, advise the client of possible Medicaid eligibility under the Katie Beckett program. (1902(e)(3) of the Social Security Act)

D-540.5 QMB/SLMB/QI1 Only to Medicaid with QMB/SLMB

a. Establish eligibility for the appropriate Medicaid category, e.g., SSI, State Institutional, etc.

b. Evaluate income and resources if applicable for Medicaid category.

c. Determine Patient Liability (P/L).

d. Update the appropriate information/STAT screens in the system, view and post a correct version to update the aid code, eligibility code, and notify the client of the change in benefits. Ensure QMB/SLMB eligibility code is not removed if posting past months.

D-540.6 Medicaid Only to Medicaid - QMB/SLMB

a. Verify current Medicare Part A enrollment/effective date of entitlement.

b. Update the appropriate MEDI-STAT screens in the system, view and post a correct version to update the aid and eligibility code. Notify the client of the change in benefits.

Note: AM1 and CA recipients cannot be eligible for Medicare and remain Medicaid eligible; convert to QMB/SLMB only.

D-540.7 Medicaid - QMB/SLMB to QMB/SLMB/QI1 Only

a. Update the appropriate information/STAT screens in the system, view and post a correct version to update the aid and eligibility code. Notify the client of the change in benefits allowing for adverse.

D-540.8 Medicaid - QMB/SLMB to Medicaid Only

a. Evaluate current monthly income; do not request verification unless a change in income occurs.

b. Evaluate current resources and compare to Medicaid resource limit (if applicable).

c. Notify the client of the change in benefits allowing for adverse action.

D-540.9 Katie Beckett to SSI

a. If a child becomes SSI eligible, terminate eligibility under Katie Beckett and approve SSI eligibility the following month.

The following are examples of conversions:

1. Applicant applies in December as a state institutional case and is currently enrolled in Medicare Part A. The client cooperates and is determined eligible as a state institutional case in December. Because this client has Medicare Part A, the case manager must also determine whether the client is eligible for QMB coverage. If the client's income and resources meet QMB criteria, QMB coverage is effective January.

2. Applicant applies January and has $250 SSA disability income. The client has not applied for SSI, but is potentially eligible. The client meets all the other requirements of a QMB.

   Once the worker is able to determine the client is eligible for QMB coverage (all verifications needed are in), the case would be approved as a QMB only case. Request the client apply for SSI and give the normal time limit for applying.

   The case would be future actioned for the SSI information. If the client failed to cooperate in applying for SSI, or was determined ineligible, the case would remain open as a QMB only case as long as he continued to meet the criteria. If the client were approved for SSI, the case would be converted to an SSI/QMB case effective with the month of SSI eligibility (this could include prior months).

3. Applicant applies and is approved for QMB coverage. Sometime after approval, the client enters the hospital for seven (7) days. The case would continue as QMB and NO PATIENT LIABILITY would be determined, UNLESS the client qualified as a state institutional case (if income is less than SSI payment level, the client does not have to be in 30 consecutive days). If the case qualifies as a state institutional case, the case would be converted and client would receive full Medicaid coverage and QMB coverage for the month of hospital stay. When the client is released from the institution, the case would be converted back to a QMB only case, allowing adverse action, as long as all disability requirements are still met.

4. Applicant applies for medical assistance in December and is pending SSI. Eligibility is evaluated under MAGI groups and the case is approved under a MAGI group. In June SSI is approved. MAGI eligibility is terminated the next month allowing for cut-off and Medicaid under the SSI group is approved the same month MAGI eligibility ends.

D-540.10 QMB and < 30 Day Hospital Stay

1. Applicant applies and is approved for QMB coverage. Sometime after approval, the client enters the hospital for 7 days. The case would continue as QMB and NO PATIENT LIABILITY would be determined, UNLESS the client qualified as a state institutional case (if income is less than SSI payment level, the client does not have to be in 30 consecutive days).

2. If the case qualifies as a state institutional case, the eligibility for the month of hospitalization would be updated to reflect the full Medicaid and QMB coverage.

3. When the client is released from the institution, the case would be converted back to a QMB only case, allowing adverse action, as long as all requirements were still met.

D-540.11 Forms Used for Conversion

2179 – Interface Consent: Request when spouse did not sign the application. Needed to access interfaces for verifying spouse's income.

2734 – Home and Community Based Waiver Eligibility Status Form: Must be filed in permanent section to verify recipient meets level of care requirements.

3004 – Disability/Incapacity Determination Request: Must be filed in permanent section to verify recipient meets disability criteria. Applicable to institutional less than 30 days, home and community based waivers, emergency medical, Katie Beckett, and prior medical.