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1. Provide definition of Post Eligibility Requirements;
2. Explain Redetermination Process for Former SSI Recipients;
3. Explain in Detail the Subsequent Application.

## **Post Eligibility Requirements**

### **1200.1 Introduction Post-Eligibility Requirements**

#### **(a) Notice of Eligibility Determination.**

The Local Department of Social Services (LDSS) shall inform an applicant of his/her legal rights and obligations and give the applicant written notification of the following:

For eligible persons:

- A finding of eligibility, the beginning, and ending dates for coverage; and
- The right to request a hearing.

For ineligible persons:

- A finding of ineligibility, the reason for the finding, and the regulation supporting the finding; and
- The right to request a hearing.

#### **(b) Recipient Responsibility**

- A recipient or his/her representative shall notify the LDSS within 10 working days of changes affecting the eligibility of a member of the assistance unit.
- A recipient or his representative shall limit use of the Medical Assistance card to the person whose name appears on the card.
- Third-Party Liability.
  - A recipient or his/her representative shall notify the LDSS within 10 working days when medical treatment has been provided as a result of any accident or other occurrence in which a third party might be liable.
  - Recipients shall cooperate with the LDSS in completing a form designated by the Department to report all pertinent information that would assist the Medical Assistance Compliance Administration (MACA) in seeking reimbursement.
  - In accident situations, recipients shall notify the LDSS of the time, date, and location of the accident, the name and address of the attorney, the names and addresses of all parties and witnesses to the accident, and the police report number if an investigation is made.
- When written notice of cancellation is received, a recipient shall discontinue use of the Medical Assistance card on the first day of ineligibility.
- Failure to comply with the provisions of §B (1), (2), and (3) of this regulation may result in the termination of assistance.

- Failure to comply with the provisions of §B (1)-(4) of this regulation may result in legal action, referral to the MACA for reimbursement, fraud investigation, or both, for illegal use of the Medical Assistance card.
- Recipients shall cooperate with the State's Quality Control review process, including provision and verification of all information pertinent to eligibility determination. Failure to cooperate shall result in the following actions:
  - The Quality Control Division shall notify the LDSS of a recipient's failure to cooperate;
  - The LDSS shall immediately attempt to secure the recipient's cooperation;
  - If the recipient still refuses to cooperate, his/her coverage shall be terminated in accordance with this provision, subject to the regulation governing timely and adequate notice.

## **1200.2 Redetermination Processing**

### **(a)Redetermination Period**

For most people who receive Medical Assistance Eligibility must be reviewed at least annually, as required by Federal Regulation. This review is called "Redetermination." During a redetermination all factors of eligibility must be met, just as they were at the initial application. Some steps required at original application may not be required at redetermination, such as verification of a social security number. The face-to-face interview is no longer required at redetermination. However, the Case Manager (CM) may require a face- to- face interview, at their option. Other steps, such as computation of earned income, are required because this data is likely to have changed since the application was originally filed.

Some individuals do not require determination of eligibility. These persons are automatically eligible for MA based on their receipt of cash benefits:

- Individuals receiving Supplemental Security Income (SSI) or Temporary Cash Assistance (TCA)
- Children in foster care or adoption under title IVE.
- Residents of Long-Term facilities who are SSI-eligible (coverage group L01) do not require a redetermination.
- The CM should set a 745 alert at least once a year to review the case for changes. Other individuals may receive eligibility only for a predetermined period of time, such as those who qualify under spend-down, but must be allowed to reapply for continued eligibility.

For those who do not require a redetermination, CARES determines the appropriate date by which the redetermination ("redet") must be completed and displays this date in the "end date"

field on the “MAFI” screen. Prior to that date, CARES will mail the appropriate application form to the recipient or representative along with a notice which advises them to complete the form and return it to the CM in order for eligibility to continue. For those who are required to have a redetermination of eligibility, eligibility for MA continues uninterrupted unless the recipient fails to:

- Return the redet application
- The CM fails to initiate the redet or
- The redet is completed and the recipient no longer meets the eligibility criteria.

In those cases, CARES generates timely and adequate notice of the closure to the recipient and sends a cancel date to MMIS. For cases where the redet application is returned and processed in a timely manner, and all factors of eligibility are met, CARES generates a notice of continued eligibility to the recipient. No information is passed to MMIS, since these individuals have on-going eligibility, i.e. no end date appears on MMIS.

For those who do not require a redetermination, such as recipients of SSI or TCA, or children in the IVE foster care or adoption, eligibility continues on an on-going basis, both in CARES and on MMIS. As long as the individual remains on the cash program or in the IVE placement, no scheduled review of MA eligibility is required. When the individual stops receiving SSI or TCA, or is removed from the IVE placement, eligibility must be redetermined, and the CM must determine if the individual qualifies in any other MA coverage group before termination of eligibility. This usually requires completion of a redetermination form. If the redetermination is not completed by the recipient, eligibility is terminated with timely notice for failure to complete the redetermination process.

If the redetermination is completed and the recipient does not qualify in any other coverage group, eligibility is terminated with timely notice specifying the reason for ineligibility. If the redetermination is completed and the recipient is eligible in another coverage group, CARES will send the appropriate notice to the recipient, a transaction to MMIS to change the coverage group code, and schedule future redeterminations.

### **(1)Expediting Reapplication**

Some recipients have eligibility in a coverage group that is time limited, such as spend-down. For these recipients, an application form will be mailed prior to the end of the current certification period. Eligibility will not continue beyond the end of the current certification, unless the application is returned and on-going eligibility is determined immediately. For most spend-down recipients, eligibility will end because a new spend-down amount must be met. This means that even if eligibility is met, there may be a gap in coverage. The purpose of sending the application form to a current spend-down recipient is to expedite the reapplication and to establish eligibility for the new period.

**Note:** For spend-down recipients, the application form will be mailed only if the spend-down has been met by the 45<sup>th</sup> day of the period under consideration and the recipient certified before CARES runs the redetermination processing. If spend-down is met after the 45<sup>th</sup> day of the

period under consideration, the CM must send the application manually. Cases that are still in preserved status at the end of the period will not receive an application.

## (2) Period under Consideration

The twelve month redetermination period should not be confused with the “period under consideration”, or budget period. The period under consideration is the period of time during which income may be considered, and is limited to six months by federal regulation. The period may be shortened, but may not be lengthened. When determining income eligibility, only income received during the six month period may be considered. Circumstances where the period under consideration is shortened include retroactive determinations and determinations for deceased applicants. While this rule has the greatest impact on spend-down cases, it is applicable in all other cases.

When determining eligibility, the six month period under consideration begins with the month of application. If income is within the standard and the applicant is determined eligible, the assumption is made that income will remain within the standard during the next period under consideration; therefore it is not necessary to complete a redetermination at the end of each period under consideration. An exception to making this assumption is when a change of income can be reasonably anticipated. In that case, the CM should set a “745” alert to confirm income at a particular point and redetermine eligibility if necessary. The second exception is when an actual change of income is reported. A change must be acted upon, regardless of the income previously calculated. A third exception to the assumption is where a retroactive determination has been made. Current eligibility is always determined separately from the retroactive period.

## (3) Certification Period

Certification period refers to the actual begin and end dates for eligibility that appear on MMIS. These begin and end dates are transmitted by CARES to MMIS through the automated interface, and may not match the end date or redetermination dates shown in CARES on the MAFI screen. Programming between the two systems has been carefully coordinated to ensure that all recipients receive the correct periods of eligibility.

**Note:** When the end date on MMIS appears as “999999”, this means there is actually no end date, and that eligibility will continue until CARES transmits an actual end date.

Coverage Group Code	CARES Redet Date	MMIS End Date	Budget Period	Redet Process	Re-Application
F01	12	None	None	X	
F02	12	None	6	X	
F03	4	None	6	X	
F04	12	None	6	X	

<b>F05</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>F98</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>F99</b>	<b>6</b>	<b>CARES date</b>	<b>6</b>		<b>X</b>
<b>P02</b>	<b>EDC + 2</b>	<b>None</b>	<b>6</b>		<b>X</b>
<b>P03</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>X</b>	
<b>P06</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>P07</b>	<b>12*</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>P08</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>P11</b>	<b>EDC + 2</b>	<b>None</b>	<b>6</b>		<b>X</b>
<b>P12</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>X</b>	
<b>P13</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>P14</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>E01</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>None</b>	
<b>E02</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>E03</b>	<b>12</b>	<b>None</b>	<b>None</b>	<b>X</b>	
<b>E04</b>	<b>12</b>	<b>None</b>	<b>None</b>	<b>X</b>	
<b>G01</b>	<b>8</b>	<b>CARES date</b>	<b>6</b>	<b>X</b>	
<b>G02</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>G98</b>	<b>8</b>	<b>CARES date</b>	<b>6</b>	<b>X</b>	
<b>G99</b>	<b>6</b>	<b>CARES date</b>	<b>6</b>		<b>X</b>
<b>X01</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>X02</b>	<b>Worker entry</b>	<b>CARES date</b>	<b>6</b>	<b>none</b>	

<b>Coverage Group Code</b>	<b>CARES Redet Date</b>	<b>MMIS End Date</b>	<b>Budget Period</b>	<b>Redet Process</b>	<b>Re-Application</b>
<b>H01</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>H98</b>	<b>12</b>	<b>None</b>	<b>6</b>	<b>X</b>	
<b>H99</b>	<b>6</b>	<b>CARES date</b>	<b>6</b>		<b>X</b>
<b>S01</b>	<b>12</b>	<b>None</b>	<b>None</b>	<b>X</b>	

S02	None	None	None	None	
S03	11/12	None	6	X	
S04	12	None	6	X	
S05	12	None	6	X	
S06	12	None	6	X	
S07	12	None	6	X	
S14	12	None	6	X	
S15	12	None	6	X	
S98	12	None	6	X	
S99	6	CARES date	6		X
T01	12	None	6	X	
T02	12	None	6	X	
T03	12	None	6	X	
T04	12	None	6	X	
T05	12	None	6	X	
T99	6	CARES date	6		X
L01	None	None	None	None	
L98	12	None	6	X	
L99	6	CARES date	6		X

\*When newborns trickle to P07, redetermination will be scheduled within 90 days of the first birthday.

**(b)**Redetermination for Former SSI Recipients – see Policy Alert 12-03 and Policy Alert 12-03 Supplement

**The automatic entitlement to Medicaid (MA) benefits continues as long as Supplemental Security Income (SSI) eligibility exists. However, when an SSI recipient loses eligibility, he/she must promptly be given the opportunity to have his/her MA benefits redetermined before those benefits are cancelled by the local department of social services (LDSS).**

**(1)** Terminations for SSI-Only recipients and SSI Recipients with Other Income

- A 90-day extension will be granted to allow continued MA benefits and inclusion into the automatic redetermination cycle. The coverage groups must be changed from S02 to the appropriate coverage group, i.e., S98, F05, P06, P14, etc. depending upon the age of the individual. Financial eligibility tests are not required to establish the 90-day extension. Income and assets will be considered beginning the month following the 90-day extension. The CM must set an alert to ensure timely completion of the redetermination for continued community MA eligibility beyond the 90-day extension, based upon the assistance unit composition. Appropriate notification must be provided in accordance with current policy and procedures for completing unscheduled redeterminations.

**Please note:** For individuals who remain eligible for MCHP (P-Track) beyond the 90-day extension, and there is no associated case, the CM must change the D.O. and transfer the finalized case to the appropriate Local Health Department (LHD). Be sure to narrate all case action.

- No face-to-face interview will be required during the 90-day extension. The procedures for tardy redeterminations apply if the application for continued eligibility is returned within four (4) months of the month in which the 90-day extension ended, or a new application is filed within that time frame.
- Individuals determined ineligible to receive MA benefits beyond the 90-day extension must be notified of the finding of ineligibility, the reason for the finding, the COMAR supporting the finding, and the right to request a hearing. The 90-day extension will allow ample time to close the case with timely notice, effective the first day of the month following the 90-day extension.

## (2) SSI Terminations with Associated Food Supplement Program Case

During the 90-day extension of MA benefits, non-SSI income must be counted to prevent a QC error and to ensure that the **Food Supplements** are calculated correctly. Code the earned income type as “FS” to prevent the system from counting it for MA, and possibly resulting in the case going into spend-down. If MA goes into spend-down, the system will not generate the proper redetermination notice.

## (3) Disabled Adult Child (DAC)

A person who is at least 18 years old, who began receiving the SSI benefits on the basis of blindness or a disability, and whose disability occurred before age 22, is referred to as a Disabled Adult Child (DAC).

When one of these individuals begins receiving Social Security benefits, based on a parent’s account that has become aged, disabled, or deceased, the SSA benefit, generally greater than the SSI benefit, results in the DAC’s loss of SSI eligibility.



Although the DAC no longer receives an SSI payment, he/she is deemed eligible for continued Medical Assistance benefits as an SSI recipient. However, because the SDX may not contain the most current information on persons who have lost SSI eligibility, the CM must contact the individual to verify Maryland Residency and that he/she is still alive. It must also be verified that the SSI termination was solely due to increased income. Despite the increased income that exceeds the medically needy income level (MNIL), these individuals remain categorically needy (S02), and therefore, do not need to complete an application form or have financial eligibility determination. Anyone meeting all of the following criteria must be certified without a lapse in coverage from the time SSI was terminated.

- The person is at least 18 years old;
- The person is a former SSI recipient who began receiving benefits on the basis of blindness or a disability, and whose disability occurred before age 22,
- The person's SSA claim number differs from his Social Security Number, and
- The claim number ends with a "c" suffix followed by a numeric, e.g. "212-22-1212 C1".

#### (4) Disabled Widowed Beneficiaries (DWB)

A widow or widower who receives SSI based on his/her own disability, but later began receiving Supplemental Security Income based on the account of the deceased spouse, is referred to as a disabled widowed beneficiary (DWB). These persons may also be referred to as "Kennelly Widows". The SSA benefit is generally greater than the SSI benefit, resulting in the DWB's loss of SSI eligibility. Although the DWB no longer receives an SSI payment, he/she is deemed eligible for Medical Assistance benefits as an SSI recipient. These persons are required to file an application. Resources may not exceed the SSI resource standard of \$2000, however, even if the income exceeds the medically needy income level (MNIL), they are still considered categorically needy (S02). Anyone meeting all of the following criteria may be certified.

- The person is a former SSI recipient;
- The person is not yet 65 years old;
- The person is ineligible for Medicare; and
- The person's SSA claim number is the social security number of the deceased spouse.  
Please note: The claim number suffix may contain the alphabetic "D" or "W".

#### (5) Pickles Amendment

The Federal Law known as the Pickle Amendment establishes Medical Assistance eligibility for certain former SSI recipients who currently receive Supplemental Security Income. Please refer to the Medical Assistance Policy Manual Chapter 3 to identify applicants who meet potential pickle eligibility and to apply the appropriate procedures for determining pickle eligibility.

**(c) Redeterminations for Former SSI Recipients CARES Procedures**

For an individual who is active in S02 but has lost SSI eligibility (per SDX, SVES), the following CARES procedures have been developed to complete the ex parte determination cycle, unless the SSI termination is due to death. Be sure to fully narrate in CARES.

**(1) SSI terminations for Adults**

- Determine the SSI termination date by completing the SDX on-line screen inquiry.
- Access the Au on CARES via the “R” option
- If the individual is under 65 years of age, go to the “DEM2” screen. If there is no disability source code entered on the “DEM2” screen complete the following:  
Enter “O” for Disab/Incap, “CF” for Approval Source Code, use the MA STAT DATE from the SDX as the Approval Source Date and as the Begin Date (MM/YY). The Disab/Incap End Date should be 90 days from the first day of the ongoing month. For example, an AU that is being reviewed in 05/02 would have the Disab/Incap, End Date of 08/02.  
If there is a disability source code entered on the “DEM2” screen change the disability approval source to Case Files ‘CF’
- If the individual is 65 or older, disability is not an issue, since the individual satisfies the age requirement.
- Go to the “UINC” screen and delete the SSI income from the on-going month.
- If other income is present, it should also be deleted. NOTE: If there is an associated food stamp AU all income (earned or unearned) must be counted as food stamp countable only.
- At the bottom of the “UINC” screen, indicate “SI” for “Appl Type”, “T” for the status and the termination date from the SDX online inquiry.
- Fast Path to the “DONE” screen and press enter.
- The “ELIG” screen should show an “S98” coverage group in pink.
- Confirm on the “ELIG” screen and then press enter.
- Confirm on the “MAFI” screen and show a “Redet End Date” of three months from the current month. For example, a case is being reviewed in April. The “Redet End Date” on the “MAFI” screen should be set to 07/02.
- In some situations the system will force you to show a past “Redet End Date” of 11 months from the “Redet Begin Date” month. In this circumstance; initiate a redetermination and set the desired end date when completing the redetermination. The notice should not be suppressed when completing the redetermination.

**(2) SSI Termination for Children**

Children under 21 years of age cannot be placed on the “S98” medical coverage group, because CARES will not generate the correct application for redetermination. Therefore, the following procedures are to be applied:

- Add-A-Program to the MA S02 for the child. The child will be the “SE” and the only member of the AU.
- Select MA type “F” and coverage group “F05” for 19 and 20 year olds.
- Select MA type “P” and coverage group “P06” for children under 19 years of age, so CARES will trickle to the appropriate coverage group.
- Use the current date as the application date.
- Go through the interview option.
  - During the interview option, close the associated S02 on a “507” code, with the “paid through date” as of the end of the current month, to prevent dual participation.
  - On the “DEM2” screen, indicate “N” in the deprivation field for the child.
  - Delete SSI income from the “UINC” screen for the ongoing month. If other income is present, it should also be deleted.
  - At the bottom of the “UINC” screen, indicate “SI” for “Appl Type”, “T” for the status and the termination date from the SDX on-line inquiry.
  - When eligibility is confirmed on the “MAFI” screen for the S02, press PF-13 to add free-form text to the S02, closing notice, indicating that MA coverage will continue for at least 90 days in a different Medicaid Coverage group.
  - When processing the application month, on the “STAT” screen use “NM” as the financial responsibility reason code for the child in order to avoid dual participation edits. Do not close the associated S02 case when processing the application month.
  - Finalize the Au. On the “MAFI” screen, set the “Redet End Date” for three months from the current month finalized in April. The “Redet End Date” should be entered as 07/02 on the “MAFI” screen.

### (3) Disabled Adult Children (DAC)

A person who is at least 18 years old, who began receiving SSI benefits on the basis of blindness or disability and whose disability occurred before the age of 22, is referred to as a Disabled Adult Child (DAC). When one of these individuals begin receiving Social Security benefits, based on a parent’s account who has become aged, disabled, or deceased, the SSA benefit, generally greater than the SSI benefit, results in the DAC’s loss of SSI eligibility. Although the DAC no longer receives SSI payment he/she is deemed eligible for continued Medical Assistance benefits as a SSI recipient. In the event that SSA does not accurately transmit this information; the individual must be certified as a Medical Assistance recipient. This information is reflected on

the SDX as “D” (Deemed in the Medicaid status field and “N01” (no payment) in the payment status field.

Anyone meeting all of the following criteria must be certified without a lapse in coverage from the time SSI was terminated. Although income exceeds the MNIL, these individuals are categorically needy (S02) and do not need to complete an application form or have a financial eligibility determination:

- The person is at least 18 years old;
- The person is a former SSI recipient;
- The person’s SSA claim number differs from his social security number; and
- The claim number ends with a “C” suffix followed by a numeric, e.g. “212-22-1212C1”.

The following procedures are to be applied:

- Delete the SSI income from the “UNIC” screen, effective the on-going month. If necessary use standard procedures for Recoveries Issues.
- Enter the SSA income, effective the same month that the SSI benefits were terminated.
- At the bottom of the “UINC” screen, enter “SI” in the “Appl type” field, and “S” in the “Stat” field. Then enter the date SSI was terminated.
- If the SSI eligibility has been closed (per SDX/SVES), enter these changes as interim changes.
- If the SSI has been terminated, the case will have to be rescreened, and changes entered before finalization.

#### (4) Disabled Widowed Beneficiaries (DWB)

A widow or widower who receives SSI based on his /her own disability, but later begins receiving Supplemental Security Income based on the account of the deceased spouse, is referred to as a disabled widowed beneficiary (DWB). These persons may also be referred to as “Kennelly Widows”. The SSA benefit is generally greater than the SSI benefit, resulting in the DWB’s loss of SSI eligibility for Medical Assistance benefits as a SSI recipient.

These persons are required to file an application. Resources may not exceed the SSI resource standard of \$2000. Even if the income exceeds the medically needy income level (MNIL), they are still considered categorically needy (S02).

Anyone meeting all of the following criteria may be certified:

- The person is a former SSI recipient;
- The person is not yet 65 years old;
- Resources do not exceed the SSI resource standard of \$2000;
- The person is ineligible for Medicare; and
- The person’s SSA claim number is the Social Security number of the deceased spouse,

The following procedure is to be applied:

- Delete the SSI income from the “UNINC” screen, effective the month of the benefits terminated.
- Enter the SSA income, effective the same month the SSI benefits were terminated.
- At the bottom of the “UINC” screen, enter “SI” in the “Appl type” field, and “ S” in the “State” field. Then enter the date SSI was terminated.
- If the SSI eligibility has been closed (per SDX/SVES), enter these changes as interim changes.
- If the SSI eligibility has already been terminated, the case will have to be rescreened, and changes entered before finalization.

### (5) Deceased Individuals

Deceased individuals are reflected on the SDX with a payment status of T01. The CARES procedures for handling deceased SSI individuals are as follows:

- On the “DEM2” screen, for the on-going month, indicate the date of death. Indicate in the narrative that the person is deceased and date of death, per SDX. Also indicate that the death filed has been updated on the “DEM2” screen, and MA SSI has closed with a paid through date as the date of death.
- The adverse action notice should be generated to the CARES address of record, just in case the information received from SSA is inaccurate.
- If an incorrect date of death has been entered, contact the DHR Help Desk for assistance. Complete a C-TAD and forward to DHMH.
- Whenever there are discrepancies between SDX and SVES information, contact the SSA District Manager. No further action may to be taken until a response is received from SSA.

### (6) Out of State Individuals

Confirm the out-of-state address by completing a SVES or SOLQ inquiry. Once confirmed, the following procedures are to be applied:

- Do not update the “Addr” screen with the new address.
- On the “Stat” screen, enter the “554” code to close the case. This action should be taken during the third week of the month, in order for the closing action to take effect at the end of the month following the month the closing action is being taken.
- The adverse action notice should be generated to the CARES address of record, just in case the information received from SSA is inaccurate.
- Include in the narrative the SDX inquiry indicates that the individual now lives out of state, and include the SVES out of state address. MA SSI is being closed, as customer is no longer a Maryland resident.
- On the “Stat” screen, enter the “554” code to close the case.

**(7) Social Security Number (SSN) Not on SDX entries on Closing List**

When there is a discrepancy between the SSNs, an SDX name search should be completed to determine the correct SSN. If the correct SSN is discovered on the SDX:

- Update the “DEM1” screen on CARES with the correct SSN. CARES should update MMIS II with the correct SSN.

If the name still appears on the closing list as SSN not on SDX during the following week:

- Submit a C-TAD to DHMH so that the SSN can be manually updated on the MMIS II.

**(d) Unscheduled Redeterminations**

- The LDSS shall promptly make an unscheduled redetermination when:
  - The person’s circumstances suggest future changes which may affect eligibility before the due date of a scheduled redetermination.
  - Relevant facts or changes in circumstances are reported by the recipient or someone on his/her behalf; or

Relevant facts or changes brought to the attention of the LDSS from other responsible sources.

- The LDSS shall notify the recipient that redetermination is required to establish continuing eligibility. Notification will be sent in a timely manner so that a decision of eligibility will be made within 30 days from the date of change.
- The LDSS shall notify the recipient of the required information and verifications needed to determine eligibility and the time standards in acting in the redetermination process.
- The LDSS shall require the recipient or his/her representative to appear in person, if the LDSS has determined that a face-to-face contact is necessary to make an accurate eligibility determination.
- All non-financial and financial factors for continuing eligibility shall be met.
- Eligibility Decisions:
  - **Eligibility Continued for the Remainder of the Certification Period:** Recipients who are determined eligible for the remainder of the certification period will be sent notice in accordance with §A(1) of this regulation.
  - **Recipients Determined Ineligible for the Remainder of the Certification Period:** Recipients determined ineligible for the remainder of the certification period because of a change in circumstances or failure to establish eligibility following a change in circumstances, shall be sent notice in accordance with §A(2) of this regulation.
- A person may reapply at any time after the cancellation of current eligibility and a new period under consideration will be established.

*Unscheduled redeterminations occur whenever the LDSS becomes aware of changes in the recipient's situation which necessitates a review of eligibility. This includes a report of a change in circumstances by the recipient, another person, and the local department's own anticipation of a change in the recipient's circumstances. When the local department becomes aware that a change is expected to occur, it is the CM's responsibility to flag the case for review at the time of anticipated change and to initiate contact with the recipient at that time.*

*Each reported change must be verified and evaluated to determine the scope of the change and its effect on the continued eligibility of the recipient. The LDSS must notify the recipient that verification of the change in circumstances is required and must be received by a given deadline. The deadline should be established on an individual case basis, taking these factors into consideration: the LDSS is expected to determine continued eligibility status within 30 days of the date of change; the recipient must report a change within 10 working days of its occurrence; the recipient must be given a timely notice (see Regulation .13B(1) for the standard on timely notice) of termination if the verified change results in ineligibility and the timely notification requirement cannot be waived based on Regulation .13B(3); the extensions of the time limits available to initial applicants do not apply to recipients undergoing unscheduled redeterminations; and failure to supply required verification by the established deadline will result in termination of Medical Assistance coverage after timely notice of termination is given.*

*A new application is not required on all unscheduled redeterminations. The CM may require completion of a new application if there are multiple or complex changes or when he cannot determine eligibility from the verification alone. A new application is required for all additions of a member to the assistance unit, other than the birth of a previously certified unborn child. Whether or not an application is required, the consideration period remains as established. A face-to-face contact is not required unless the LDSS decides that it cannot make an accurate determination without such contact. The recipient who is determine ineligible based on verified information must have his eligibility terminated at the earliest date consistent with the timely notice requirements. A recipient who was eligible without spend-down may have his/her certification terminated because of increased income which renders him/her potentially eligible only under spend-down. This person's prior certification period will be preserved for possible spend-down eligibility at any time within the existing consideration period.*

#### (e)Scheduled Redeterminations

- The LDSS shall make scheduled redeterminations at least once every 12 months for non-institutionalized and institutionalized persons certified pursuant to Regulation .11C of this chapter.
- The LDSS shall notify the recipient that redetermination is required to establish continuing eligibility. The notice and application will be sent at least 45 days before expiration of the current certification period.
- When the signed application is received by the LDSS, a new period under consideration will be set. The new period will be related to the date the application is received but may not include any month in which the person was entitled to coverage under the current certification period.

- A recipient shall be treated the same as an applicant at the time of scheduled redetermination.
- All non-financial and financial factors of eligibility shall be met.
- The LDSS shall make timely decisions in accordance with the provisions of Regulation .04L of this chapter.
  - **Eligibility Decisions:**
  - Eligibility Established - Applicants who are determined eligible for a new period under consideration shall be sent adequate and timely notice.
  - Ineligibility Established - Applicants determined ineligible for the new period under consideration shall be sent adequate and timely notice.
- When ineligibility is due to excess income only, the applicant will be provided with an explanation of the spend-down provision. Spend-down eligibility may be established at any time during the new period under consideration.

*The application, when filed by the recipient at any time within the last 45 days of the certification period, establishes a consideration period of six months which begins with the first day of the month following the last month of certification. No retroactive consideration period based on the application filed within the last 45 days of the certification period is allowed. A face-to-face interview is not required unless the local department decides that it cannot make an accurate determination without an interview.*

*The recipient must provide information about current income, current-resource, identify unit composition, or any non-financial eligibility factors. The CM must identify required verifications and give the recipient a deadline for supplying them. This deadline should precede the end of the current certification period so that the CM has some time to evaluate submitted verifications, determine eligibility before the expiration of the current certification period, and record continuing eligibility without delay for those recipients who remain eligible for Medical Assistance.*

*The extensions of the basic time limits available to initial applicants (see Regulation .04I (4)) also apply to re-applicants and must be kept in mind when establishing deadlines for submission of information. Any deadlines established for submission of verifications may not be adhered to so rigidly that the local department refuses to accept and evaluate verifications submitted after the established deadline but before the end of the current certification period. However, the recipient should be advised at the time the deadlines for submission of verifications is established that some interruption in coverage may occur if he does not submit the required verifications before the deadline.*

- **Subsequent Application.** A person may reapply when eligibility is not met during the periods established in SC (1) and (3) of this regulation.

### **1200.3 Certification of Creditable Coverage**



The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that all Medicaid program issue Certificates of Creditable Coverage to any recipient whose eligibility is terminated, or who requests a certificate at any time. “Creditable Coverage” means any comprehensive insurance coverage.

A Certificate of Creditable Coverage verifies that the individual had coverage prior to requesting enrollment in a new health plan. This is important because many health plans refuse to cover individuals with costly medical conditions, or may refuse to pay for services related to such conditions. These coverage exclusions are based on the premise that the condition was preexisting. Change in federal law under HIPPA now prevent insurers from excluding persons or services from coverage based on preexisting conditions if it can be shown that the person was continuously covered by any health plan. For Medical Assistance recipients, this is very important because those who are able to get jobs and become financially independent need to be able to obtain private insurance coverage for themselves and their children. To meet the requirements of the law, the certificate must include the following information:

- Date the certificate is issued
- Name of the Program, i.e. Maryland Medical Assistance
- Name of Recipient
- The Date Coverage began, or the date 180 months prior to the certificate issue date, whichever is later,
- The name, address, and telephone number of the issuer
- The end date of coverage, or if coverage is ongoing as of the date of the certificate, a statement to that effect.
- A telephone number to call for further information

The Law Requires that Certificate is issued:

- Upon request. Whenever a person requests a certificate, the Program is obligated to provide one. This is true whether the eligibility has been terminated or is ongoing. A person may request a certificate up to 24 months after termination of coverage and the Program is obligated to provide it. The Program may elect to provide certificates beyond that time frame but is not required to do so by the law.
- Upon termination of creditable coverage. Whenever a person loses eligibility in a coverage group that is considered creditable, a certificate must be issued. Loss of eligibility would be a complete cancellation of eligibility, or a change in coverage group from a group that is creditable to one that is non-creditable, e.g. a change in certification from Primary Adult Care Program (PAC). A loss of eligibility is defined as a gap in coverage for more that 63 days; therefore, a briefer period of ineligibly does not require that a certificate be issued. Not all of Maryland’s Medical Care Programs are creditable. Some of our Medical Care Programs offer only limited health benefits. These include the Primary Adult Care (PAC) and the Maryland Family Planning Program (MPP).

#### **1200.4 Tardy Redeterminations**

Regulations and policy require prompt redetermination of eligibility for all categories when changes occur which may affect eligibility, i.e., disability, living arrangements, income, resources, etc. Reapplication following the termination of eligibility always began a new period under consideration, and a face-to-face interview was required to complete the process.

To simplify the process, a new procedure is being implemented to allow a “Tardy Redetermination” for recipients who lose Medicaid eligibility due to failure to complete the redetermination. This means the recipient failed to return the redetermination packet, failed to return requested verifications, or failed to notify the CM of difficulty in providing required information. Effective immediately if, under any circumstances, an individual loses MA eligibility for failure to complete the scheduled or unscheduled redeterminations, the CM must process the application without a face-to-face interview if:

- The redetermination packet is returned within four months of the month the MA benefits were terminated,; or
- A new application is filed within four months of the month the MA benefits were terminated.

If the redetermination packet or a new application is received by the LDSS/LHD within four months of the case closure, eligibility can be determined back to the month in which eligibility was lost, meaning there may be no lapse in coverage. To facilitate this process, take the following steps:

1. The screener should run a clearance to find the most recent MA case closure for the individual and determine if it was processed within the past four months.
2. Rescreen the case, using the first day of the month following the month in which eligibility was lost as the application date (e.g., if case closed on 5/31/01, use 6/01/01 as the effective date).
3. Process each month, since the month of case closure, evaluating the circumstances, i.e. living arrangements, income and assets, etc. For each pending month, review and enter the actual gross income and resources for that month, to ensure that eligibility existed during each month.
4. Certify for months in which eligibility existed. If it is determined that the individual’s eligibility would have continued uninterrupted if he/she had completed the redeterminations timely, certify the case with no lapse coverage, beginning the first day of the month following the month in which eligibility was terminated.
5. If the individual was ineligible during any months since the month of case closure, certify only for the month(s) for which eligibility is established. If the individual was ineligible during the entire period, send proper notification, including the finding of ineligibility and dates, the reason for the finding, the COMAR supporting the finding, and the right to request a hearing.

These procedures are consistent with existing policy regarding retroactive application.

## (a) CARES Procedures for Tardy Redeterminations:

1. The screener should run a clearance to find the most recent MA case closure for the individual and determine if it was processed within the past four months.
2. "J" screen the closed AU, using the first day of the month following the month in which eligibility was lost as the application date (i.e., if case closed on 1/31/2002, use effective 2/1/2002 as the effective date).
3. Complete the interview ("O") Process on CARES.
4. In Processing (P) evaluate the technical and financial circumstances, (i.e. living arrangements, income and assets, etc.) for each pending month, since the month of case closure. Review and enter in the actual gross income and resources for each month to ensure that eligibility existed.
5. Certify for months in which eligibility existed. If it is determined that the individual's eligibility would have continued uninterrupted if he/she had completed the redetermination timely, certify the case with no lapse in coverage, beginning the first day of the month following the months in which eligibility was terminated.
6. If the individual was resource ineligible during any months since the month of case closure, allow CARES to determine eligibility, which will result in the AU denial due to over scale resources. Send proper CARES notification. The customer would then need to file a new application. Note: On the denial notice use PF13 to explain the exact resource that was used to determine ineligibility for the AU. Be specific to allow the customer the ability to re-apply as soon as possible when resources are within scale.
7. If the individual was income ineligible during any months since the month of case closure, the case manager should allow CARES to determine eligibility, which may result in the AU going into spend-down. Send Proper CARES notification.

REMINDER: UPDATE THE NARRATIVE TO REFLECT ALL ELIGIBILITY DECISIONS.

### **1200.5 Procedures for DES 501 Admission to Long-Term-Care( LTC)- Less Than 30 Days**

Upon receipt of the DHMH 257 showing a stay of less than 30 days, the LDSS must make sure that the individual is eligible for Medical Assistance prior to completion of the DES 501 form, and its submission to this office. If the recipient is enrolled in an MCO on the date of admission, the request cannot be processed, as the MCO is responsible for the first 30 days of admission. Please take the following steps when processing the case.

Step1. Review the faxed or mailed DES 501 received from the LDSS for completeness the completed form:

- Must have a began date
- Must have a date of discharge
- Must be signed and dated by the LDSS worker
- Must have the Provider's I.D. Number

- Must include the excess amount remaining on the day spend-down was met, if the recipient was certified under spend-down

Step 2 . A completed DHMH 257 must be attached to the 501. Make sure the completed 257:

- Has “Community M.A” written across the top
- Has an Admission Date, Begin Pay Date, Date of Discharge, and Level-of-Care authorization by Delmarva. PLEASE NOTE: It is not necessary to receive Delmarva approval for Medicare co-payment requests.
- For QMB- Only co-payment request the Long-Term-Care span may remain open for as long as the recipient’s admission is covered under Medicare, i.e., 21<sup>st</sup>-100<sup>th</sup> day.

Both forms DES 501 and DHMH 257 must be received before the request can be processed. If the LDSS fails to submit both documents the document submitted will be returned, unprocessed, to the LDSS.

Step 3 . Enter the requested dates onto Screen #4 to open the Long-Term-Care span. If the system rejects the span:

- Determine why the span was rejected
- Return unprocessed documents to the LDSS with a notation

Step 4 . After the Long-Term-Care span has been opened, notify the providers by fax or mail within 14 days that the transaction has been completed. Use the notification form developed for providers.

NOTE: The LTC/SP Unit may receive phone calls from providers if claims for stays of less than 30 days have been rejected and the recipients were fee-for-service on the dates of admission. If provider concerns cannot be addressed by the LTC/SP Unit refer to the providers to DHR’s Problem Resolution Unit at 410-767-8699.



501 NOTIFICATION LETTER

DATE

ADMINISTRATOR  
LONG-TERM-CARE FACILITY  
MAILING ADDRESS

DEAR MR/MS \_\_\_\_\_:

This notice is to advise you that a Long-Term-Care span has been opened for (Patients Name, MA Number) covering the period (Begin Date to Date of Discharge). The covered period is for a length of stay of less than 30 days requested by the LDSS.

If you have any questions regarding this notice, please call Ms. Jewel Bennett at (410) 767-4913. Thank you.

Sincerely,

Willard Dixon, Manager  
Long –Term-Care/Special Projects Unit

SAMPLE LETTER

July xx, 2000

Mr. Roger Kurtz, Administrator  
The Wesley Home, Inc.  
2211 West Rogers Avenue  
Baltimore, MD 21209

Dear Mr. Kurtz:

The notice is to advise you that a Long-Term-Care span has been opened for Mary Medicaid, 00-999999999, covering the period 7/15/00 to 7/30/00. The covered period is for a length of stay of less than 30 days requested by the Baltimore City Department of Social Services.

If you have any questions regarding this notice, please call Ms. Jewel Bennett at (410) 767-4913. Thank you.

Sincerely,

Willard Dixon, Manager  
Long- Term-Care/Special Projects Unit

**Section 1200 Frequently Asked Questions (FAQ's) and Answers  
Post-Eligibility Requirements**

1. Who shall inform an applicant of his/her legal rights and obligations and give the applicant written notification of the following of ineligibility and eligibility?

The Local Department of Social Services (LDSS) /Local Department Health (LDH) shall notify the applicant of ineligibility or eligibility.

2. Who shall notify the LDSS/LHD within 10 working days of changes affecting the eligibility of a member of the assistance unit?

A recipient or his/her representative shall notify the LDSS/LHD of change affecting eligibility.

3. How should a CM confirm out of state address for out of state individuals?

A CM should confirm the out-of-state address by completing a SVES or SOLQ inquiry

4. How many months can a redetermination packet or a new application are received where eligibility can be determined back to the month in which eligibility was lost, meaning there is no lapse in coverage?

Four months.

5. During what period of MA benefits, non-SSI income can be counted to prevent a QC error and to ensure that the Food Stamps calculate correctly?

During the 90-day extension period the non- SSI income can be counted to prevent a QC error and to ensure that the Food Stamps calculate correctly.