MA-3410 TERMINATIONS, DELETIONS AND EX PARTES

REVISED 08/01/13 - CHANGE NOTICE 04-13

I. INTRODUCTION

Whenever an individual/family is determined ineligible for Medicaid in any aid program category, including Work First/Benefit Diversion, he must be evaluated for ongoing Medicaid eligibility in all other aid program/categories. In most cases, the evaluation should be done as an ex parte review. To ensure this evaluation occurs when Work First terminates, EIS will not allow the case to be terminated for any reason except for those listed in II.A. All other Work First terminations must be transferred to MAF-C. The MAF-C certification period is the remainder of the Work First payment review period or 2 months, whichever is greater.

The term "ex parte review" means to review information available to the agency to make a determination of eligibility, without requiring the beneficiary to come into the agency or make a separate application. A signed redetermination document is not required. The county must explore and exhaust all possible avenues of eligibility in all Medicaid coverage groups as well as NC Health Choice. If information is not available to make a determination of eligibility, the county must provide the beneficiary reasonable opportunity to provide the necessary information.

When evaluating ongoing Medicaid eligibility for an individual/family at the end of a Medicaid certification period, including the MPW postpartum period, or at the end of a Work First payment review period, a full redetermination must be completed. At the end of a Work First payment review period, transfer the case to MAF-C for 2 months. Complete a full redetermination during these 2 months. Refer to V.B. Always send appropriate notices before termination. Do not require the individual to provide information that does not change such as birth certificates, etc.

When reviewing ongoing Medicaid eligibility, if you establish eligibility in an aid program category that requires creation of a case in EIS, a signed application is not required. Enter the DSS 8124 as an administrative new application/reapplication.

II. EXCEPTIONS TO CONTINUING MEDICAID WHEN MEDICAID, INCLUDING WORK FIRST, TERMINATES

A. When an individual or case becomes ineligible for one of the following reasons do not evaluate for on-going Medicaid.

1. Moved out of state, or

2. Individual (s) deceased, or

3. Casehead voluntarily requests termination of Work First and/or Medicaid,

(II. A. 3.)

a. The request must be in writing and specifically request Medicaid termination. If it is a Work First case, the casehead must specifically request termination of Medicaid as well as Work First.

b. File the written request in the case record. The record must include documentation that the individual understood that he and/or the children may still be eligible for Medicaid and chose not to continue.

c. If the request is for Work First termination and there is no written request for termination of Medicaid, authorize for MAF-C through the remainder of the Work First payment review period or 2 months, whichever is greater. Complete an ex parte review to determine ongoing Medicaid eligibility prior to the end of the certification period.

4. Individual(s) incarcerated in federal prison, state juvenile justice facility, county or local jail (refer to MA-3360, Living Arrangement for instructions).

Note: The eligibility of individuals incarcerated in North Carolina Department of Public Safety, Division of Prisons (DOP) facilities, or of those age 21 thru 64 in institutions for mental disease, are placed in suspension if they remain otherwise eligible (see MA-3360, Living Arrangement for instructions).

5. Unable to locate,

a. Document all reasonable attempts to locate the family. This includes searching all other agency records, both paper and computer records, if no older than 6 months. For example, search Food Stamps, ACTS, Service Records (Child Care, etc.), ESC, SDX, OLV, SOLQ and EPICS.

b. If the most recent address is not current, attempt to locate a telephone number to contact the family. A current address is:

(1) Part of an active record in another program (such as Food stamps, services or IV-D records).

(2) Part of an inactive record in another program which had active benefits or eligibility for benefits occurred within the past 6 months. Any activity in the case in the previous 6 months, except for mail returned as undeliverable, is sufficient to consider the address current.

(3) From any source outside the agency if no older than 6 months.

(4) If the location of the payee is unknown, but you know the child(ren)'s location, authorize the child(ren) for Medicaid. or

(II. A.)

6. Failure to cooperate with IV-D without good cause. Failure to cooperate in seeking monetary child support is not a basis for Medicaid termination. The duty to cooperate in seeking medical support also applies to caretaker only cases when the eligible child(ren) receives SSI unless the caretaker is pregnant. Refer to MA-3365, Child Support, III. when the caretaker is pregnant, or

7. The only person receiving Work First Family Assistance has been approved for SSI benefits, or

8. Failure to complete or provide information for a Medicaid redetermination review. **This is not a Work First review.**

9. Failure to apply for benefits to which entitled.

B. Instructions For Terminating

1. Document the reason for the termination in the case record and note the reason Medicaid is also being terminated. It must be one of the exceptions listed above.

2. Refer to the EIS User's Manual for the correct termination/deletion code to generate an automated notice. **Never use "Other"**. If this is a Work First case, no additional Medicaid termination notice is required.

III. REQUIREMENTS FOR EX PARTE REVIEW WHEN AN INDIVIDUAL BECOMES INELGIBLE FOR MEDICAID OR WORK FIRST

A. Whenever a change in situation causes an individual to become ineligible for Medicaid or Work First, complete an ex parte review to evaluate for Medicaid in any possible aid program/categories. Refer to II.A. for the exceptions. The possible aid program/categories are listed below. Citizenship/identity documentation is not required during an ex parte review.

1. Family and Children's Medicaid

   a. MAF-C including,

      (1) MAF-C for Job Bonus (MAF-C), refer to MA-3300, Income. Ensure you evaluate under both budgeting methodologies in MA-3300, Income.

      (2) MAF-C, refer to MA-3405, Twelve Months Transitional Medicaid.

      (3) Caretaker relative of an individual under age 19.

   b. Four Month Transitional Medicaid (AAF payment type 4). Refer to MA-3400, Four Months Transitional Medicaid.

   c. MIC-N for individuals under 19.

(III.A.1.c.)

If a Work First recipient turns 18 and has protected SSI status, transfer the child to MIC and begin the adult disability review process. Refer to Adult Medicaid MA-2525, Adult Medicaid Disability.

d. 12 month continuous eligibility for individuals under age 19 (MIC) if ineligible for any other categorically needy Medicaid coverage group and there are months remaining in the 12 month period since the last determination.

(1) If more than 2 months remain in the 12 month period following Work First termination, authorize for the remainder of the 12 months.

(2) If 2 or fewer months remain in the 12 month period following Work First termination, evaluate for NC Health Choice and Medically Needy coverage following the 2 month period.

Do not terminate categorically needy coverage until after a timely notice is sent.

The 12 month continuous period should be documented in the case record at application and at each redetermination.

e. NC Health Choice for individuals ages 6 - 18. If there is a freeze, follow the policy regarding actions to be taken during the freeze.

f. Expanded Medicaid (MIC-1) for individuals ages 0 through 5 with income greater than 185% or 133% and equal to or less than 200% federal poverty level.

g. MAF-N when anyone in the assistance unit is age 19 – 20.

h. MPW, if it is known to the agency that the recipient is pregnant. Refer to MA-3240, Pregnant Woman Coverage. If medical verification of the pregnancy is not in county records, contact the recipient to request verification of pregnancy to evaluate for MPW. **(**See DMA-5137, Ex Parte Verification of Pregnancy, for example of request**)** Allow 12 calendar days to provide verification of pregnancy. If more time is needed to get the verification, allow an additional 12 calendar days.

i. MAF for women who qualify for the Breast and Cervical Cancer Medicaid (BCCM). Refer to MA-3250, Breast and Cervical Cancer Medicaid.

j. MAF-D Medicaid Family Planning Waiver (FPW) for anyone that qualifies for FPW. Refer to MA-3265, Family Planning Waiver Medicaid.

k. Expanded Foster Care Program (EFCP) under HSF or IAS for anyone that qualifies. Refer to MA-3230, Eligibility Of Individuals Under Age 21.

2. Aged, Blind and Disabled Medicaid

a. MAA when anyone in the assistance unit is age 65 or older.

(III. A. 2.)

b. MAD when anyone in the assistance unit receives Social Security disability, or there is a DMA-4037 in the record indicating that an individual has been determined disabled and the disability has not been subsequently denied/terminated. (For HCWD see MA-2180.)

c. MAD for SSI children with protected status. Refer to the Adult Medicaid manual, MA-2525, Disability.

A child with protected Medicaid status must be covered in MAD-N if he meets the eligibility criteria for MAD-N. Authorize the child in a Family & Children's Medicaid category only if he is ineligible for MAD-N.

A child with protected Medicaid status who is turning age 18 must have a disability review by Disability Determination Services to determine if he meets the adult disability criteria. Follow procedures in MA-2525, Disability, for a disability review.

d. MAB when anyone in the assistance unit meets Social Security's definition of blindness. Refer to the Adult Medicaid manual, MA-2530, Blindness (For HCWD see MA-2180)

3. If the individual/family is ineligible under categorically needy requirements, evaluate eligibility for Medically Needy under all coverage groups in which he can be included.

a. If the individual is eligible for Medicaid but must meet a deductible, contact the recipient regarding his old, current and anticipated medical expenses to determine if he can meet the deductible. The deductible can be met if:

(1) His deductible amount is $300 or less, or

(2) His old, current and anticipated medical expenses are within $300 of meeting the deductible.

b. Follow EIS instructions to establish the necessary case. If the individual is also eligible for FPW, process the MAF-D case. The applicant/recipient may choose to either receive or not to receive FPW while the application/redetermination is pending to meet a deductible. Explain to the a/r expenses that can be used toward a deductible. An a/r may have one active and one pending application in EIS.
Follow EIS procedures in EIS USER'S MANUAL Section 2012 when the a/r meets the deductible or is approved for disability. Send an adequate notice to terminate the FPW case. Terminate the MAF-D case when the a/r meets the deductible.

c. If it is determined that the individual's deductible is greater than $300 or his old, current and anticipated medical expenses are not within $300 of meeting the deductible, send timely notice to propose termination. If eligible for FPW, send appropriate notice. Establish case in EIS if eligible.

4. Refugee Medical Assistance (RMA) if the family/individual is a refugee and not eligible under any aid program/category. Refer to the RMA manual.

(III.)

B. Begin the evaluation for ongoing Medicaid as soon as it is determined that the family/individual is ineligible.

C. Do not require a signed application or redetermination document.

D. Unless questionable, consider information obtained at the last Medicaid/Work First review as current. Information from a previous review is not current for MIC/NCHC reenrollments.

E. Verification Requests

1. Reverify only those eligibility factors that are subject to change: such as;
   a. Income,
   b. Household composition or
   c. Resources.

2. Do not reverify factors that are not subject to change, such as
   a. Date of birth
   b. Citizenship.

3. Information must be obtained from an active agency file. An active agency file includes:
   a. An active case or
   b. A pending application within the DSS agency or
   c. An FNS case in suspense

4. The information must be current. Current information means it was obtained and verified:
   a. In another program or
   b. In another Medicaid case and
   c. Within the time frames for redeterminations of eligibility for the Medicaid coverage group being considered. Time period is determined by the certification period for the program being evaluated. These time frames apply to all sources of information, including SDX.

      Example: If the recipient is being evaluated for MAF Medically Needy and the certification period is 6 months, the information must have been verified within the last 6 months. If the recipient is being evaluated for MIC and the certification period is 12 months, the information must have been verified within the last 12 months. In both of these situations the other program must be active, pending or an FNS case in suspense at the time the information is obtained.

5. Information obtained from a closed or terminated program can not be used even if verified during the appropriate time frames.

(III. E.)

6. Available to the agency includes information available through automated queries, such as:
   a. THE WORK NUMBER
   b. SDX
   c. BENDEX
   d. OLV
   e. FSIS
   f. SOLQ
   g. ESC or
   h. Other reliable internet based sources of employment and wage verification. (Refer to MA-3515, Automated Inquiry and Match Procedures, and EIS Manual 1100 Volume I for instructions on using the SDX, BENDEX and other online inquiries.) and
   i. Information collected in the determination of eligibility for other programs if the information can be released by the other programs within its rules for confidentiality, such as:

      (1) Food and Nutrition Services
      (2) Work First
      (3) Child Care Assistance
      (4) IV-D- Child Support Services
      (5) Adult or Children Services

7. If the names of immediate family members (spouse, parents and stepparents, adult or minor children, and siblings) who live with the individual are known, check all records in their names and complete on-line matches. See DMA-5138, Non MIC/NCHC Ex parte Checklist and the DMA-5075, Verification Checklist for MIC/NCHC Re-enrollments. for a checklist to document family members.

8. Contact the casehead if additional verification is needed which is not available to the agency. Contact may be by telephone or in writing. If a telephone request is made, advise the casehead what information is needed and that he may request additional time or assistance in obtaining necessary information.

9 Document the record to show the date of the telephone contact, the specific information requested and that the recipient was offered assistance. If the request is in writing, use the DMA-5097, Request for Information.

   a. Explain to the casehead that he is responsible for providing necessary verification within 12 calendar days of the request. If the casehead needs more time, allow another 12 calendar days.

   b. If verification is not received, send a timely notice proposing termination for failure to provide necessary information. Failure of the caretaker to return requested information does not affect continuous eligibility for the children.

(III. E. 9.)

c. Timely notice can be sent no earlier than the workday following the due date on the DMA-5097, Request for Information.

d. Do not terminate an individual for failure to provide information unlikely to change or for information that is available to DSS.

F. If the entire case or individuals in the case are ineligible for ongoing Medicaid in any aid program/category including Adult Medicaid or NC Health Choice, document the record and send a timely notice to terminate Medicaid.

G. If ongoing eligibility is established, continue with the remainder of the current certification or payment review period or a new certification period if needed. A new certification period is needed if the current one has expired. The length of the new certification period is based on the aid program/category. Refer to MA-3425, Certification and Authorization.

For example, establish a 12 month certification period for MIC or Health Choice, 6 month certification period for MAF-M or MAD, or through the post-partum period for MPW.

H. If eligibility cannot be established in the timeframe, extend eligibility one month at time until eligibility is established for all Medicaid aid program/categories. Ensure the appropriate notice is mailed prior to termination.

I. Continued Coverage of Pregnant Women Who Lose Eligibility in an Aid Program/Category Other Than MPW

1. A woman who is pregnant and who loses eligibility in any aid program/category (including adult Medicaid as well as Family & Children's categories) may be eligible for continued coverage through the postpartum period under MPW if her countable income as determined by MPW policy does not (or at any time during her pregnancy did not) exceed the MPW income limit.

   a. If it is known and verified by the agency that the recipient is pregnant, evaluate for MPW.

   b. If pregnancy verification is not contained in the agency records, contact the recipient to request verification of pregnancy (refer to DMA-5137, Ex Parte Verification of Pregnancy). Allow 12 calendar days to provide verification of pregnancy. If more time is needed to get verification, allow an additional 12 calendar days.

      If there is no information in county records to indicate pregnancy, do not evaluate for MPW.

      NOTE: This does not apply to individuals terminated from SSI. Refer to MA-1000 of the Adult Medicaid Manual for requirements for SSI ex parte reviews when a pregnant woman is terminated from SSI.

(III.I.)

2. Certain terminations also cause ineligibility for MPW. These include (but are not limited to):

   a. The woman moves out of state; or

   b. The woman becomes an inmate of a public institution; or

   c. The woman, if age 21 or older, is an inpatient in a private psychiatric hospital.

3. Work First or MAF-C or N Terminations

   a. Certain pregnant individuals will be eligible for MPW based on information already verified. These are cases in which:

      (1) A Work First or MAF-N or C assistance unit includes a woman who is pregnant (the postpartum period is included as part of the pregnancy); and

      (2) A change causes the case to be ineligible or the pregnant woman to lose eligibility; and

      (3) The change would not cause a loss of benefits under MPW regulations

   b. Examples of situations which might terminate Work First or MAF-C or N but would not affect MPW eligibility include, but are not limited to:

      (1) Failure to come in for a redetermination, or

      (2) Increase in income or resources, or

      (3) The case goes into deductible status for MAF; or

      (4) For Work First families:

         (a) Failure to follow SFU requirements, or

         (b) Failure to return a quarterly report, or

         (c) Failure to sign the Mutual Responsibility Agreement, or

         (d) Failure to register with ESC for First Stop, or

         (e) Move from one county in NC to another, or

         (f) Termination due to an electing county requirement, or

         (g) Expiration of the 24/60 month time limit, or

         (h) Expiration of the Benefit Diversion period, or

         (i) Failure to comply with pay-after-performance requirements.

(III.I.3.)

c. Evaluation for pregnant woman coverage for MAF-C or N or Work First terminations.

(1) Determine whether the entire case should receive continued Medicaid based on:

(a) 12 month Transitional Medicaid (MA-3405, Twelve Months Transitional Medicaid

(b) 4 month Transitional Medicaid due to child or spousal support (MA-3400, Four Months Transitional Medicaid).

(2) If the case qualifies for one of these Medicaid continuations, follow procedures in those applicable sections. At the end of the continuation period, follow procedures in those sections to determine whether the case includes a pregnant woman who should be transferred to MPW.

(3) If the entire case does not qualify for one of these Medicaid continuations, and the pregnant woman meets all the requirements in MA-3240, Pregnant Woman Coverage, the county dss must authorize Medicaid for the pregnant woman under MPW

4. Procedures to continue pregnant woman's Medicaid under MPW:

a. Send a timely notice to terminate current coverage and authorize MPW. (MPW is a lesser benefit as it covers only pregnancy related services).

b. Establish an MPW certification period beginning the month following loss of MAF or Work First authorization through the last day of the month of the postpartum period.

c. Follow instructions in the EIS User's Manual to terminate the Work First or MAF case or delete the pregnant woman and transfer her to MPW.

d. If the pregnant woman is receiving in a category that does not allow a transfer to MPW, terminate or delete her from the original case and enter an administrative application to authorize MPW. No signed application is required.

J. Benefit Diversion / Open Shut

1. When Benefit Diversion ends, evaluate the family for ongoing Medicaid.

a. Whenever possible, an ex parte review should be completed prior to the end of the Benefit Diversion timely notice period. If eligible for Medicaid, authorize assistance in the appropriate aid program/category.

b. If ineligible for Medicaid or the ex parte review can not be completed before Benefit Diversion benefits are terminated, authorize the family for MAF-C.

(1) The MAF-C certification period is 2 months.

(2) Complete the ex parte review as soon as possible after transfer to MAF-C.

(III.J.1.b.)

(3) Ensure that all other aid program/categories including Families and Children, NC Health Choice, and Medicaid for the Aged, Blind, and Disabled are considered.

(4) If eligible for Medicaid, authorize assistance in the appropriate aid program category.

(5) If ineligible for Medicaid, send timely notice to terminate assistance.

2. Timely notice should be sent as soon as ineligibility for Medicaid is established.

3. A second party review is required whenever an individual/family is terminated from Benefit Diversion and not authorized for ongoing Medicaid.

IV. REQUIREMENTS FOR EX PARTE MIC/NCHC RE-ENROLLMENT

A. Conduct an ex parte review for re-enrollments of eligibility for both MIC and NCHC programs for children under the age of 19. Use the Case Management Report to identify MIC/NCHC cases due for re-enrollment.

1. The recipient is not required to complete a re-enrollment form.
2. The Case Management Report includes MIC and NCHC cases due for review three (3) months prior to the end of the certification.
3. The ex parte review date begins the first day of the 11th month of the current certification period. Do not react to changes in income that occur after the first day of the 11th month of the current certification period, unless the assistance unit was ineligible based on income verified in the ex parte process. Document the change in the case record for verification at the next review.

B. Review the case file to determine if any changes have been reported.

C. Review On-line verifications (OLV).

D. See III.E. above for verification requests.

E. Verifications of income cannot be used from the last re-enrollment of case being reviewed.

F. The DMA-5075, Verification Checklist for MIC/NCHC Re-enrollments is the base document for the ex parte re-enrollment. Document all verifications on this form. File the completed DMA-5075 in the case record.

G. If ongoing eligibility is established, authorize for the next certification period in the correct aid program category.

H. If the entire case or individuals in the case are ineligible for ongoing assistance in any aid program/category, including NC Health Choice, document the record and send a timely notice to terminate Medicaid/ NCHC.

V. WHEN WORK FIRST TERMINATES

A. Evaluate The Terminated Work First Case/Deleted Individuals For MAF-C during the Work First Payment Review Period

The entire case/individuals may be terminated from Work First for a reason that does not affect Medicaid eligibility. In these situations, the entire case or deleted individuals remain eligible for Medicaid. **No separate eligibility determination is needed.** When Work First terminates for one of the following reasons and there are no other known changes that affect eligibility, authorize for MAF-C. The MAF-C certification period is the remainder of the Work First payment review period or two months, whichever is greater. If other changes are known, complete an ex parte review once the case/individual is transferred to MAF-C. See V.B.below,. This list is inclusive.

1. Failure to sign the Mutual Responsibility Agreement, or
2. Failure to register with ESC for First Stop, or
3. Failure to comply with drug screening requirements, or
4. Family moves from one county in North Carolina to another county in North Carolina,
    a. Transfer the case to MAF-C for the remainder of the Work First payment review period or two months, whichever is greater.
    b. If the MAF-C certification period is more than 2 months, follow procedures in Section 204 of the Work First Manual and Section MA-3340, County Residence, of the Family and Children's Medicaid Manual to complete the county transfer.
    c. If the MAF-C certification period is two months, a full redetermination must be completed prior to initiating the county transfer. See VII.B.below, or
5. Termination is due to an electing county requirement.

B. Evaluate the Terminated Work First Case/Deleted Individuals for MAF-C at End of the Work First Payment Review Period

1. When a case is determined ineligible for Work First at redetermination, all individuals in the case must be evaluated for ongoing Medicaid including NC Health Choice.
    a. At the end of the Work First timely notice period, transfer the case to MAF-C. The MAF-C certification period is 2 months.
    b. Complete a full Medicaid redetermination of eligibility.
    c. Ensure that all other aid program/categories including Families and Children, NC Health Choice, and Medicaid for the Aged, Blind, and Disabled are considered.
    d. If eligible for Medicaid, authorize assistance in the appropriate aid program category.
    e. If ineligible for Medicaid, terminate assistance following timely notice.

(V.B.)

2. When an individual/family is determined ineligible for Work First due to a change in situation, the individual/family must be evaluated for ongoing Medicaid including NC Health Choice and FPW.

   a. Whenever possible, an ex parte review should be completed prior to the end of the Work First timely notice period. If eligible for Medicaid, authorize assistance in the appropriate aid program category.

   b. If the ex parte review can not be completed before Work First benefits are terminated for the individual/family or if Medicaid ineligibility is established for the entire case, authorize the individual/family for MAF-C prior to terminating Medicaid benefits.

      (1) The MAF-C certification period is the remainder of the Work First payment review period or two months, whichever is greater.

      (2) Complete the ex parte review as soon as possible after the transfer to MAF-C.

      (3) Ensure that all other aid program/categories including Families and Children, NC Health Choice, and Medicaid for the Aged, Blind, and Disabled are considered.

      (4) If the individual/family is eligible for Medicaid, authorize assistance in the appropriate aid program/category.

      (5) If the individual/family is ineligible for Medicaid, terminate following timely notice.

3. If an **individual** is determined ineligible for Medicaid, terminate assistance as soon as possible following timely notice.

   a. For individual deletions from the Work First case, this can be in the same month that the Work First timely notice period expires.

   b. A transfer to MAF-C is not required for individuals deleted from a Work First case when the ex parte review establishes ineligibility and a manual timely notice is sent to the individual to terminate Medicaid the same month that Work First terminates.

4. Timely notice should always be sent as soon as ineligibility for Medicaid is established.

5. A second party review is required whenever an individual/family is terminated from Work First and not authorized for Medicaid. Refer to VII.B.below.

   Example: Individual does not respond or provide information requested for the Work First review. At the end of the Work First timely notice period, transfer the case to MAF-C for 2 months. Prior to the end of the MAF-C certification period, complete a full redetermination to establish ongoing Medicaid.

(V.)

C. EIS Automatically Transfers Certain Work First Cases To MAF-C

EIS automatically transfers the entire Work First case to MAF-C for the remainder of the Work First payment review period or two months, whichever is greater when the case is not manually transferred by the pull deadline for terminations due to the reasons listed below. The county is expected to complete work in a timely manner. Cases should not be allowed to automatically transfer in EIS. As in V.A.above, these reasons for terminating Work First do not affect Medicaid eligibility.

1. Expiration of the 24/60 month limit, or
2. Expiration of the Benefit Diversion period, or
3. Failure to comply with pay-after-performance requirements, or
4. Failure to return the Work First quarterly report by the 2nd keying deadline.

Automated transfers are identified on the case management report to indicate an MAF review is due. An ex parte review must be completed for automated transfers during the MAF-C certification period. If eligible for ongoing assistance, authorize in the appropriate aid program/category. In addition, transfers to MAF-C due to expiration of the 24/60 month limit, pay-after-performance, benefit diversion, and failure to return the Work First quarterly report are identified in NCXPTR under "AAF AUTO TRANSFERS TO MAF".

D. Work First Terminations Due to Earned Income

When the case is determined ineligible for Work First due to new or increased earned income of the caretaker, determine whether the case is eligible for Twelve Months Transitional Medicaid. Refer to MA-3405, Twelve Months Transitional Medicaid.

Note: Do not terminate unless having evaluated for Job Bonus (Job Bonus should have already been given).

1. If eligible for Transitional Medicaid, transfer the entire case to MAF-C for 12 months. Follow EIS instructions to enter Special Review Code.
2. The Work First automated notice informs the casehead of the effective date Work First stops and the months the case is eligible for Medicaid due to Transitional Medicaid. **No additional Medicaid notice is required.**
3. If ineligible for Twelve Months Transitional Medicaid, complete an ex parte review as soon as possible.
   a. If eligible for Medicaid or NC Health Choice, authorize in the appropriate aid program/category.
   b. If ineligibility is established, terminate following timely notice.

(V.)

E. Notices

1. When the entire case is transferred to MAF-C, the Work First termination notice states: "Your payment will be stopped. Your Medicaid continues." **No additional Medicaid notice is required** until the Medicaid ex parte review is completed.

2. When an individual is deleted from Work First, the notice states: "Your payment will be reduced/stopped. Your Medicaid eligibility is being evaluated. You will receive a separate notice about Medicaid." **No additional Medicaid notice is required** until the Medicaid ex parte review is completed.

3. When an individual is determined ineligible for Medicaid prior to authorizing MAF-C, a manual timely notice is required regarding ineligibility for Medicaid.

   a. The timely notice period for Medicaid ineligibility must end the same month the Work First benefit ends.

   b. If the timely notice does not end by the pull date of the month Work First terminates, the individual must be authorized for MAF-C for the remainder of the Work First payment review period or 2 months, whichever is greater. Terminate effective the end of the first month of the MAF-C certification period following timely notice.

VI. WHEN MEDICAID TERMINATES

A. Evaluate the Terminated Medicaid Case/Deleted Individuals during the certification period

Any time it is determined that a family or individual is ineligible for Medicaid, the caseworker must evaluate each individual to determine whether he is eligible for Medicaid in any other aid program/category or NC Health Choice. DO NOT TERMINATE MEDICAID UNTIL A DETERMINATION IS MADE, AND THE TIMELY NOTICE PERIOD HAS EXPIRED.

B. Evaluate the Terminated Medicaid Case/Deleted Individuals at the end of the certification period

Complete a full redetermination with a signed redetermination document to determine ongoing eligibility in all Medicaid categories and NC Health Choice when Medicaid ineligibility is established at the end of:

1. Medicaid certification period, or

2. MPW postpartum period, or

   Prior to the end of the MPW 60 day postpartum period, begin the redetermination process for the pregnant woman. This is not an automated re-enrollment. A manual appointment notice and/or re-enrollment form must be sent to the pregnant woman.

3. Work First payment review period.

(VI.)

C. Evaluation for ongoing eligibility when pregnant woman coverage ends

When pregnant woman coverage ends (MPW or MAF), evaluate the pregnant woman for ongoing Medicaid eligibility and a complete redetermination completed.

1. Evaluation at end of postpartum period

   a. Prior to the end of the 60 day postpartum period, the pregnant woman must be evaluated for coverage in all other Medicaid aid program/categories.

      Because the certification period for pregnant woman coverage is the period of the pregnancy and the 60 day postpartum period, this evaluation is a redetermination of eligibility. Refer to MA-3420, Re-Enrollment.

   b. Evaluate her for possible eligibility under all other aid program/categories.

      (1) MAF if she is under 21 or is now the caretaker of an eligible child,

      (2) MIC or NC Health Choice if she is under 19,

      (3) MAB if there is evidence that blindness has been established: she receives Social Security due to blindness or there is a DSB-2202 in the record that establishes blindness,

      (4) MAD if there is evidence that disability has been established: she receives Social Security due to a disability or there is a DMA-4037 in the record that establishes disability, or

      (5) MQB if she has Medicare coverage.

      (6) FPW if she is age 19 through 55 and has income at or below 185% federal poverty level.

      (7) IAS or HSF under Expanded Foster Care Program if she was in foster care at age 18 or had aged out of foster care at age 18.

   c. Verification Requests

      (1) Reverify only those eligibility factors that are subject to change, such as income, household composition or resources. Do not reverify factors that are not subject to change, such as date of birth or citizenship.

      (2) Information must be requested only when it is necessary to determine ongoing eligibility AND the information is not already available to the agency or is not current.

         See DMA-5138, Non- MIC_NCHC Ex Parte Checklist, for a suggested checklist to document agency records reviewed.

(VI.C.1.)

d. Do not terminate Medicaid until the redetermination of eligibility is completed.

(1) If it is not completed by the end of the postpartum period, authorize for an additional month to complete the redetermination. Repeat this process as long as necessary to complete the redetermination.

(2) If the woman is not eligible for ongoing Medicaid, send a timely notice advising her that her Medicaid is terminating. If the timely notice period does not end before the end of the postpartum period, extend the authorization for another month.

e. If the woman is eligible for ongoing Medicaid,

(1) Terminate the MPW coverage effective the last day of the month in which ongoing eligibility was determined.

(2) Her ongoing certification period begins with the month following the termination of MPW coverage. The certification end date is the date required for the aid program/category in which she is authorized for ongoing eligibility. Refer to MA-3425, Certification and Authorization.

(3) If the pregnant woman is eligible in a category that does not allow a transfer from MPW, terminate the MPW and enter an administrative application to authorize in the new category. No signed application is required.

2. Change in situation causes ineligibility in MAF

When a change in situation in MAF pregnant woman coverage causes ineligibility, evaluate for coverage in other coverage groups. This evaluation is an ex parte review. Follow procedures in MA-3410, Terminations, Deletions and Ex Partes, for evaluating Medicaid eligibility when an individual loses eligibility under her current coverage group.

a. If the pregnancy terminates, follow procedures in 1.

b. If the pregnant woman is covered under MAF-C, change her to MPW and authorize through the end of the 60 day postpartum period.

c. If the pregnant woman is covered under MAF-M, evaluate for coverage under other aid program/categories. Do not terminate her Medicaid until she has been determined ineligible for Medicaid under all other aid program/categories.

VII. SECOND PARTY REVIEW OF WORK FIRST FAMILY ASSISTANCE AND BENEFIT DIVERSION DENIALS AND TERMINATIONS

A second party review is required any time Work First Family Assistance, Benefit Diversion or Transitional Medicaid terminates and all assistance unit members are not authorized for Medicaid or NC Health Choice.

A. The director determines which staff in the agency will conduct the second party review. The review might be done by supervisory staff, either Work First or Medicaid, or the director may wish to establish a second party review team to share the responsibility. (See DMA-5139, Second Party Review Plan-WF to Medicaid)

B. Second Party Review Requirement

1. Conduct a second party review if all assistance unit members are not authorized for Medicaid/NC Health Choice when Work First is denied or terminated. This also includes individuals not approved for Medicaid when Work First approves other members of the assistance unit.

2. Conduct a second party review when any individual is deleted from an ongoing WFFA/Benefit Diversion/Transitional Medicaid case and the individual is not approved for Medicaid or NC Health Choice.

3. Conduct a second party review if it appears action was not taken timely during the Work First/Benefit Diversion ex parte review process.

4. Evaluate for Medicaid and second party reviews prior to the 45th day for denied Work First/Benefit Diversion applications.

5. Use the "Second Party Review Sheet", DMA-5140, Second Party Review Sheet, for documentation of all second party reviews (required).

   Remember that all Medicaid application processing time standards apply from the date of the Work First /Benefit Diversion application. For any Work First/Benefit Diversion application pending on the 45th day, the county must have established a timeframe by which the case was evaluated and second party reviewed for Medicaid eligibility**.**

   Once the review sheet has been completed, it must be signed by the person conducting the review and placed in the case record. The county may choose to design its own checklist; however, it must contain all the required information as outlined on the DMA-5140-Second Party Review Sheet. The form should be updated as policy changes**.**