CHANGE IN CIRCUMSTANCE, TERMINATIONS, AND REOPENING

REVISED 02/01/24 – CHANGE NO. 02-24

Change No. 02-24:

- Subsection D. Changes Discovered on an Application – Eligibility Determined via the Marketplace, has been added to MA-3410, section I. Policy Principles.

- Subsection D. provides policy and procedures for local agencies when new information is discovered while working with information verified on a determination of eligibility by the Federally Facilitated Marketplace (FFM). Eligibility determined by the FFM is final and any new information must be treated as a change of circumstance, even if the new information is discovered prior to authorizing Medicaid.

I. POLICY PRINCIPLES

A. Introduction

When determining Medicaid eligibility, the applicant/beneficiary (a/b) must be evaluated for all Medicaid programs when a change of circumstance has been reported. When the local agency learns of a change during the certification period that potentially impacts continuing eligibility, a full redetermination must be completed.

B. Definitions:

1. **Change in circumstances:** Any change in a beneficiary's circumstances that may affect eligibility for Medicaid. Changes may include, but are not limited to:

   a. Income changes

   b. Changes in household composition

   c. Changes in living arrangement

2. **Critical age:** There are three age limits at which eligibility criteria for MIC beneficiaries must be evaluated: age 1, 6, and 19.

3. **Transitional Medicaid:** A parent/caretaker beneficiary may receive up to twelve months of Transitional Medicaid (TMA) when they are determined ineligible for MAF-C because of new or increased income. Refer to MA-3405 Twelve Month Transitional Medicaid for policy requirements.

   Note: As a reminder, continuous eligibility applies for children under the age of 19. See exceptions to continuous eligibility in MA-3305, MAF, MIC, HSF Budgeting.

4. **Ex-parte process**: a determination of Medicaid eligibility utilizing information available to the local agency without requesting verification from the beneficiary. This may be electronic sources or information verified by other programs, such as Food and Nutrition Services (FNS) or Work First Family Assistance (WFFA). When information and/or verification must be requested from the beneficiary, the ex-parte process ends.

5. **Reasonable Compatibility:** Reasonable compatibility refers to the standard used to compare the self-attested income/resources and income/resources as reported by an electronic data source. Reasonable compatibility applies to all categorically needy programs and must be applied anytime there is a self-attestation and an electronic source for income/resources. Refer to MA-3310, Reasonable Compatibility.

C. Reacting to the Change in Circumstance

1. Appropriate action must be taken within 30 calendar days after the local agency learns of the change.

2. Begin the ex-parte evaluation for ongoing Medicaid as soon as it is determined that the beneficiary is ineligible for the current Medicaid program.

3. Do not require a signed application or recertification document.

4. Benefits may not be reduced or terminated based on electronic source information only.

5. If verification cannot be obtained electronically, or if the change will result in a reduced benefit or ineligibility for any Medicaid program, follow instructions in II.D. below for sending the DHB-5097/DHB-5097sp, Request for Information.

6. Permit on a case-by-case basis self-attestation by beneficiaries of any eligibility requirement except citizenship and immigration status when documentation doesn't exist or is not reasonably available, such as for individuals who are homeless or victims of domestic violence or natural disaster.

7. The local agency must obtain the verification for the individual and document in NC FAST when:

    - there is a fee involved in obtaining the information OR
    - if the individual requests assistance OR
    - the individual is mentally, physically, or otherwise incapable of obtaining the information.

8. The beneficiary is allowed to have any third person to assist in the evaluation process.

9. Review all agency records to determine if the beneficiary has one or more of the following:

   a. A power of attorney

   b. Legal guardian

   c. Authorized representative

   Refer to MA-3430, Notice and Hearings Process policy for a complete list and policy requirements.

10. When assistance is needed, it must be provided in a manner accessible to persons with disabilities or limited English proficiency.

    Home visits may be made only at the request of the beneficiary when needed. Home visits may be used to assist the beneficiary in providing information needed to complete the review. Beneficiaries may request a home visit due to incapacity or other good cause.

D. Changes Discovered on an Application – Eligibility Determined via the Marketplace

February 1, 2024: the Federally Facilitated Marketplace (FFM) determines Medicaid and Marketplace eligibility for residents of North Carolina, when the individual applies for medical coverage at the FFM. The determination of eligibility and any FFM verifications included on the application case file are final and will not require any additional follow up.

1. When an FFM application has been received by NC FAST and there is FFM Determination evidence present, but the application could not be authorized by NC FAST via the straight through process (STP):

   a. The application must be authorized by the local agency.

   b. The determination of eligibility by the FFM is **final** and may not be changed.

2. When an application is received from the FFM and there is **no** FFM Determination evidence present, but there are FFM verifications:

   a. The caseworker **must not** reverify any item that has been verified by the FFM.

   b. The caseworker must attempt to verify any outstanding verification utilizing electronic sources, agency files or other programs prior to requesting information from the applicant(s).

3. Any new or contradictory information discovered during the verification and authorization process may only be reacted to **after** the application has been authorized.

   a. The caseworker must treat any new information as a change in circumstance.

   b. The caseworker must determine if the discovered change can be made following appropriate notification, or if continuous eligibility applies to the individual (i.e., child under 19, MPW).

   c. If the change is allowable, the caseworker must follow all applicable policy and procedures found throughout this policy section to complete the change.

   d. The caseworker should refer to NC FAST Job Aid: FFM Determination Processing for keying instructions applicable to updating FFM determination evidence and FFM verified evidence.

E. Telephone or In-Person Contact

At every in person or telephone contact, the caseworker must offer assistance to the individual with creating an ePASS account, and with linking/delinking their ePASS account.

- The option to **link** their ePASS account is not available to a/bs who DO NOT have a Social Security Number and sufficient credit history.
- Refer to
  - Dear County Director Letter (DCDL) posted on May 18, 2022
  - The Learning Gateway training, ePASS Linking & Delinking Enhanced Accounts
  - NC FAST Job Aid: ePASS Linked Accounts Change of Circumstance

F. Franklin v. Kinsley Requirements: Beneficiary Alleging Disability

Franklin v. Kinsley (5:17-CV-581 E.D.N.C.) – previously known as Hawkins v. Cohen, is a federal lawsuit filed in 2017 on behalf of Medicaid beneficiaries in North Carolina.

Beneficiaries receiving full Medicaid in any Family and Children's program, including MPW, and who allege disability may be eligible to have their benefits continued while a disability determination is made.

1. Caseworkers must follow policy found in MA-3421, MAGI Recertification to determine if a DHB-2187 was mailed to the a/b.

2. Benefits may not be reduced or terminated earlier than 60 calendar days after the date the DHB-2187 was mailed.

II. WHEN MEDICAID TERMINATES – CHANGE OF CIRCUMSTANCE

A. Beneficiary Ineligible

1. When a change in circumstances is reported that results in the beneficiary being determined ineligible for Medicaid, the caseworker must evaluate the beneficiary for all Medicaid programs.

2. Beneficiaries who are eligible for Medicaid due to SSI or State/County Special Assistance who report a change in circumstance must be evaluated for all Medicaid programs.

3. Do not terminate Medicaid until the beneficiary is evaluated for all Medicaid programs, and the timely notice period has expired.

B. Transitional Medicaid

When a change of income is reported, evaluate the parent/caretaker for Transitional Medicaid.

Refer to MA-3405, Twelve Months Transitional Medicaid.

C. Ex-parte Review

1. When SSI terminates, refer to MA-3120, SSI Medicaid for guidance.

2. If verification cannot be obtained electronically, or if the change will result in a reduced benefit or ineligibility for any Medicaid program, follow instructions in II.D. below for sending the DHB-5097/DHB-5097sp, Request for Information.

3. When State/County Special Assistance (SA) terminates, determine ongoing eligibility for all Medicaid programs prior to termination of SA.

   Refer to MA-3420 and 3421 for policy regarding the ex-parte process.

D. Requesting Verification

Only request information needed to verify the reported change of circumstance.

1. When information is required that cannot be verified using electronic sources, the caseworker must request the required verifications by generating and sending the DHB-5097/DHB-5097sp, Request for Information.

2. Only ask for information about individuals living in the home who are financially responsible for those persons receiving or requesting Medicaid coverage.

3. Refer to II.D. below, for information to be included on the DHB-5097/DHB-5097sp, Request for Information when the reported change will result in eligibility for another Medicaid program, or ineligibility.

4. The local agency must obtain the verification for the individual and document in NC FAST when:

   - There is a fee involved in obtaining the information OR
   - If the individual requests assistance OR
   - The individual is mentally, physically, or otherwise incapable of obtaining the information

5. Do not terminate the beneficiary for failure to provide information unlikely to change or for information that is available to the local agency.

6. Allow 12 calendar days for the beneficiary to respond to the DHB-5097/DHB-5097sp, Request for Information.

E. Using Collateral Contacts

Collateral contacts are used to substantiate or verify information necessary to establish eligibility.

1. Collateral contacts include specific individuals, business organizations, public records, and documentary evidence. Specific alternative collateral contacts that may be used for verification are outlined in the eligibility determination sections.

2. For more information about allowable contacts, see the policy section related to the evidence type being verified, i.e., if verifying income, review the appropriate policy section for income.

3. Collateral contacts should only be used if the evaluation for Medicaid cannot be completed ex-parte.

4. Limit collateral contacts to those necessary to obtain the required valid information and where the beneficiary requests assistance or cannot obtain the needed verification.

5. If the beneficiary/representative does not want the local agency to contact necessary collateral contacts, ask them to obtain the information themselves.

6. If the beneficiary does not cooperate in providing/obtaining the necessary verifications, terminate the case following timely notice requirement see MA-3430, Notice and Hearings Process.

7. Update/add verification on the evidence dashboard of the income support case in NC FAST.

Refer to the following NC FAST Job Aids:

a. Managing Spend Down Evidence

b. Income & Expense Evidence Wizards – Income Support

c. Adding Evidence to Cases

d. Verifications

e. NC FAST Mandatory Evidence and Verifications

F. Returned Mail/Unable to Locate

1. Document all attempts to locate the beneficiary. Documentation must include the date of the attempt and the outcome.

   a. Review agency records and other program records for a current address including:

      - Food and Nutrition Services (FNS)
      - Work First Family Assistance (WFFA)
      - Other agency records and/or electronic sources as needed

   b. Review electronic sources for an updated address, including OVS results for:

      - ACTS
      - ESC
      - SDX
      - SOLQ
      - TWN-(can only be completed inside of NC FAST due to contractual requirements)

   c. Attempt to contact the beneficiary by telephone to obtain a current address.

   d. Send a DHB-5097/DHB-5097sp, Request for Information to the most recent mailing address to request verification of a new address.

2. If all attempts to locate the beneficiary are unsuccessful:

   a. Ensure that all requirements regarding the DHB-2187, Notice of Potential Change in Medicaid Eligibility, are followed. Refer to I.E., above.

   b. Medicaid benefits may not be terminated until 60 calendar days after the date the DHB-2187 was mailed.

   c. The caseworker must review the DHB-2187 in NC FAST to determine

the date mailed. Then use the Time Standards chart to calculate the 60th calendar day.

d. Send an **adequate** DSS-8110 to terminate Medicaid effective the last day of the month in which the 61st day falls. Follow policy in MA-3430, Notice and Hearings Process.

3. If the local agency **is able to locate** the beneficiary prior to the end of the current certification period, reopen the terminated case from the first day of the month after the month of termination and authorize benefits through the end of the certification period.

Example:

- On 8/5, the local agency learns of a change of circumstance that may impact Medicaid eligibility for a beneficiary who is certified through January of the following year.
- The caseworker discovers that additional information is required to evaluate for all programs and mails the beneficiary a DHB-5097 on 8/10.
- The caseworker receives returned mail on 8/28 with no forwarding address for the beneficiary.
- The caseworker then follows the policy in steps one and two above. After exhausting all efforts to locate the beneficiary including assuring that 60 calendar days have passed since the DHB-2187 was mailed, the caseworker terminates the case using the reason "unable to locate" effective 10/31 and mails adequate notice to the beneficiary.
- On 12/15, the beneficiary contacts the caseworker after a medical provider informs them that their Medicaid is not active.
- The beneficiary provides a new address, and the caseworker reopens the case, authorizing benefits beginning 11/1 through 1/31 (the original certification end date).
- Because the caseworker originally was unable to complete the evaluation for the reported change, and the case was terminated prior to the tenth month of a twelve-month certification period, a new certification period cannot be authorized until the recertification is completed.
- The caseworker must follow the steps in four, below.

4. When the original returned mail item is the DHB-5097/DHB-5097sp, Request for Information, mailed by the caseworker to request verification required to evaluate the reported change of circumstance, take the following steps when the local agency **is able to locate** the beneficiary prior to the end of the **current** certification period:

a. Generate and mail another DHB-5097/DHB-5097sp, Request for Information, requesting the same information that is needed to evaluate the reported change of circumstance.

b. Allow the beneficiary 12 calendar days to provide the information.

c. If the 12th calendar day is in the month after the certification period ends, extend the certification period for one month at a time until the recertification process is complete.

d. If the beneficiary fails to respond or is no longer eligible, and there is not enough time to mail timely notification after the 12th calendar day, extend the certification period for one month at a time until the timely notification process is complete.

Example:

- Using the same scenario in the example under II.F.3. above, the caseworker reopened the case and generated and mailed the DHB-5097 requesting the same information required to evaluate the reported change of circumstance.
- The beneficiary returns the information, however, the information provided results in ineligibility for all Medicaid programs.
- The caseworker determined the beneficiary is ineligible on 12/21 and generates and mails timely notice which expires in January.
- Because timely notice does not expire before the end of the current certification period (12/31), the caseworker extends the benefits for one month, with the end date of 1/31.

III. MEDICAID CONTINUES – CHANGE IN CIRCUMSTANCE

A. Evaluate for All Programs

1. Always evaluate for all Medicaid programs. This includes all MAGI (Modified Adjusted Gross Income) and non-MAGI Medicaid programs.

2. When the beneficiary is eligible for Medicare, evaluate for all Medicaid for Qualified Beneficiaries (MQB) programs.

3. When a beneficiary reports an increase or change in income that results in ineligibility for MAF-C, the beneficiary may be eligible for TMA. Refer to MA-3405, Twelve Month Transitional Medicaid for policy requirements.

4. If verification cannot be obtained electronically, or if the change will result in a reduced benefit or ineligibility for any Medicaid program, follow instructions in II.D. above for sending the DHB-5097/DHB-5097sp, Request for Information.

B. Refugee Medical Assistance

When a change is reported by a beneficiary who meets the requirements for Refugee Medical Assistance (RMA), refer to the Refugee Assistance Manual for guidance. Review NC FAST evidence and case documentation to determine if the a/b's citizenship status meets the requirements for refugees.

C. Medicaid Continues – No Program Change

When the reported change in circumstance results in continued eligibility for the same Medicaid program, or when the change of circumstance cannot be reacted to per the appropriate policy:

1. Document the details of the change and the reason for continued eligibility.

2. Generate and mail an adequate DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance. Select the appropriate reason when accepting the changed decision in NC FAST to ensure that the correct notice is generated to continue benefits with no change:

    a. MAGI: "CoC No Change MAGI"

    b. Non-MAGI: "CoC No Change"

D. Medicaid Continues - Program Change

After completing a full evaluation for all Medicaid programs, the caseworker determines that the a/b remains eligible for Medicaid in another program, take the following actions:

1. If the reported change results in a new or changed deductible for medically needy Medicaid, or results in eligibility for a limited benefit Medicaid program (i.e., MQB-Q/B/E or family planning):

    a. Send a DHB-5097/DHB-5097sp, Request for Information prior to sending timely notification:

        (1) Request both paid and unpaid medical bills and anticipated medical expenses to meet the new six-month deductible, or the applicable deductible period for the case situation. Accept the beneficiary's statement of anticipated medical expenses if it reasonably shows that the deductible may be met by anticipated medical expenses (scheduled surgery, for example).

        (2) The DHB-5097/DHB-5097sp **must** include the new deductible amount.

        (3) The DHB-5097/DHB-5097sp **must** include the amount and source of the income used to calculate the deductible and that the beneficiary must notify the local agency if the amount of

income has changed or is incorrect.

b. Allow 12 calendar days to provide requested information.

c. Send a timely DSS-8110 for a program change, after the 12 calendar days if applicable

d. For medically needy changes:

(1) Make the necessary changes in NC FAST.

(2) For beneficiaries already eligible for medically needy Medicaid, accept the changed decision in NC FAST to update the deductible on the product delivery case (PDC). Ensure that the DSS-8110 notice generated includes the new deductible amount.

(3) For beneficiaries who are eligible for a categorically needy full Medicaid program at the time the change is reported:

(a) Accept the changed decision on the categorically needy, full Medicaid PDC.

(b) Ensure that the DSS-8110 notice generated includes the deductible amount.

(c) Close the categorically needy, full Medicaid PDC in NC FAST.

Refer to NC FAST Job Aid: Closing a Case

(d) Authorize the new medically needy Medicaid PDC from the eligibility check.

(e) If the beneficiary provided medical bills to meet the new deductible, enter the appropriate evidence and activate the medically needy Medicaid PDC.

(f) If the beneficiary has not provided medical bills sufficient to meet the deductible, do not activate the PDC.

2. If the non-MAGI beneficiary is determined eligible for a MAGI Medicaid program:

a. Accept the changed decision on the current non-MAGI Medicaid case to generate the applicable timely or adequate notice, based on ongoing eligibility.

(1) If eligibility is changing from a non-MAGI Medicaid

program to a MAGI program with equal or greater Medicaid benefits,

(a) Mail an adequate DSS-8110 notice.

(b) Key an administrative MAGI application.

(c) Close the non-MAGI PDC.

Note: Refer to NC FAST Job Aid: MAGI – Application to Case to key a new application.

(2) If eligibility is changing from a non-MAGI full Medicaid program to a MAGI limited benefit program, (i.e., FPP),

(a) Mail a timely DSS-8110 notice.

(b) Key an administrative MAGI application.

(c) Close the non-MAGI PDC.

Note: Refer to NC FAST Job Aid: MAGI – Application to Case to key a new application.

b. After authorizing and activating the new PDC, generate and mail a DHB-5003, Medicaid or NC Health Choice Approval Notice.

E. Certification Period

1. When the reported change of circumstance results in continued eligibility for the same Medicaid program, continue with the remainder of the current certification. If the change of circumstance is reported during the recertification process, refer to recertification policy found in MA-3420/3421.

2. When the reported change of circumstance results in a program change, approve a new certification period. The length of the new certification period (six-months or 12-months) is based on the Medicaid program.

3. If eligibility cannot be determined prior to the end of the current certification period, extend eligibility one month at a time until eligibility is determined for all Medicaid programs. Ensure the appropriate notice is mailed prior to continued eligibility, termination or changing to a reduced benefit program. Refer to MA-3420/3421, Recertification for policy regarding determining eligibility at recertification.

IV. EXCEPTIONS TO CONTINUING MEDICAID

A. Exceptions to Evaluating for On-Going Medicaid

When an individual becomes ineligible for one of the reasons listed in IV.B. below, do not evaluate for on-going Medicaid.

B. Reasons to Terminate Medicaid:

1. Moved out of state,

2. Individual is deceased,

3. Case head voluntarily requests termination of Medicaid

   a. If the request is in writing:

      (1) The request must specifically request Medicaid termination.

      (2) Maintain the written request with the case in NC FAST.

      (3) The record must include documentation that the individual understood that they and/or their children may still be eligible for Medicaid and chose not to continue.

      (4) Adequate notification is required, utilizing the DSS-8110.

   b. If the request is received via telephone or in person:

      (1) Explain to the beneficiary that they or their children may still be eligible for Medicaid. Document that the individual understood and chose not to continue.

      (2) Provide the beneficiary with a DHB-2050, Voluntary Request to Terminate Medicaid, and explain that their signature is required.

      (3) **Exception:** when the verbal request is made because the beneficiary has moved to another state and they are applying for Medicaid in the new state, document in NC FAST and accept a verbal request for termination. Follow timely notification policy found in MA-3430, Notice and Hearings Process.

4. Individual who is over the age of 21 and is not former foster care is incarcerated in a federal prison, 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, is placed in suspension if they remain otherwise eligible. (see MA-3360, Living Arrangement for instructions).

5. When the local agency is unable to locate the a/b or has returned mail, follow instructions in II.F. above.

6. Failure to apply for benefits to which entitled.

V. NOTIFICATION REQUIREMENTS

When the a/b is no longer eligible for Medicaid or is eligible for another Medicaid program, notification must be provided to the a/b and/or their authorized representative. Refer to MA-3430, Notice and Hearings Process

A. Timely Notification

1. Timely notice can be sent no earlier than the next business day following the due date on the DHB-5097/DHB-5097sp, Request for Information.

2. When one or more beneficiaries included in the case are ineligible for ongoing Medicaid in any Medicaid program or are eligible in a program with reduced benefits, follow the steps below.

   a. Document the reason for termination or reduction of benefits on the case in NC FAST.

   b. Send a timely DSS-8110 notice to terminate Medicaid.

      Refer to NC FAST Job Aid: MA/MAGI DSS-8110 Notice of Modification, Termination, or Continuation of Public Assistance, for instructions.

B. Adequate Notification

1. When eligibility has been determined and the a/b will continue to be eligible for the same or greater benefit, an adequate DSS-8110 notice must be sent.

2. Adequate notification must also be sent when the Medicaid benefits are extended for an additional month while eligibility is being determined.

VI. TERMINATION AND REOPEN

A. Terminations

1. When it is determined that one or more beneficiaries no longer meet eligibility requirements for any Medicaid program, the caseworker must terminate the case in NC FAST after following timely notification procedures.

2. When ongoing eligibility cannot be determined due to the a/b failing to provide the required verifications, the caseworker must terminate the case in NC FAST after following timely notification procedures.

B. Re-opening a Terminated Case

1. Termination due to failure to provide information at recertification:

   a. **MAGI**: If the case was terminated at recertification, allow the a/b 90 calendar days to provide the required information, including a signed NCFAST-20020.

   b. **Non-MAGI**: if the case was terminated at recertification, allow the a/b **90 calendar days** to provide the required information.

2. Termination due to a change of circumstances

   Cases which have been terminated may be reopened if the request to reopen is received no later than the 90th calendar day following termination.

   If the 90th calendar day falls on a non-business day, allow the a/b until the next business day to make the request.

   The following criteria must be met prior to reopening a terminated case:

   a. The case was terminated for one of the following reasons:

      (1) If the MAGI case was terminated at recertification, allow the a/b 90 calendar days to provide the required information. For non-MAGI cases, allow ten calendar days. Refer to VI.B.1. above.

      (2) Reported change in circumstance that impacts eligibility.

      (3) Unable to locate the beneficiary.

      (4) The beneficiary moved out of state.

      (5) The beneficiary became a resident of a public, non-medical institution (individual was released prior to the 90th calendar day following month of termination).

   b. All information needed to reopen the case must be received by the 90th calendar day of the month following the month of termination.

      This includes but is not limited to:

      (1) Required verifications that cannot be verified ex-parte

      (2) HCWD enrollment fee when applicable

      (3) HCWD premium when applicable

c. All individuals included in the case when it was terminated must be included in the reopened case.

d. The individuals must be eligible in the same Medicaid program as the terminated case.

3. Verify eligibility continues.

If the case was terminated for the following changes in circumstances, accept the a/b's statement as verification of current residence/living arrangement for the household:

a. Unable to locate.

b. Moved out of state.

c. Resident of a public, non-medical institution (see IV.A.4.).

4. Reopen the case.

a. Reopen the PDC in NC FAST.

b. Enter the certification period as follows:

(1) When reopening a case that was terminated during the certification period, the certification begin date is the first day of the month following the month of termination. The certification end date is the end date of the certification period in the original case.

Example:

The case being reopened was originally certified from January 1 through December 31. The case was terminated effective June 30. Reopen the case with a certification period of July 1 through December 31, if the missing information was provided by July 10th.

(2) When reopening a medically needy case with a deductible, do not re-compute the deductible if the certification period entered is less than six months unless there was a change in income.

c. The Medicaid effective date must be no earlier than the first day of the month following the month of termination.

5. If, at any time during the reopening process, it is determined that the case cannot be reopened, and a signed application is required:

a. The date of application is the date of the first initial contact.

b. Follow all requirements for an application. Refer to MA-3200, Application.

c. The application does count in the county's report card.