

**L-0000 CHANGES****L-100 REQUIREMENT**

Applicants/enrollees are required to report changes to an agency representative when the changes occur.

Federal regulations require a prompt re-evaluation of eligibility when changes are reported. Only the eligibility factors affected by the changed circumstances should be re-evaluated. Other eligibility factors should be considered at the next regularly scheduled renewal.

**Exception:**

Twelve (12) months continuous eligibility for children under age 19 must be explored before terminating a child's eligibility. Refer to [H-1910 General Information](#).

**L-200 CHANGES REQUIRED TO BE REPORTED**

The following changes must be reported for the applicant/enrollee or any member of the income/resource unit within ten (10) days of the occurrence \*\*: :

- Source of income;
- Amount of income;
- Changes in household composition;
- Birth;
- Death;
- Pregnancy or end of pregnancy;
- Value or ownership of a resource, including the acquisition of a new resource;
- Change of address;
- Receipt of a lump-sum payment or settlement;
- Admission to or discharge from an institution, including a long term care (LTC) facility;
- Change of case management agency;
- School attendance of a \*\* child, age 18 or over;

**Note:**

School attendance is applicable only in the Parents and Caretaker Relatives Group and in the MAGI-Based Medically Needy Program.

- Other medical insurance coverage and the premium amounts;
- Information regarding an absent parent;
- Disability status; and
- The responsible person of a LTC applicant/enrollee.

**LTC Only**

The LTC facility is required to report to the agency:

- Admissions, transfers, deaths, and discharges; and
- Any changes in the applicant/enrollee's income or resources of which facility personnel becomes aware.

**Home and Community-Based Services (HCBS) Only**

The case management agency is required to report to the Medicaid agency:

- Admissions, deaths, discharges, and transfers (including transfers to another case management agency and temporary absence of HCBS waiver services due to placement in a hospital, nursing facility, respite center or other medically necessary program with the intent to return to waiver); and
- Any changes in the applicant/enrollee's income or resources of which provider personnel becomes aware.

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The Office for Citizens with Developmental Disabilities (OCDD) or the Office for Aging and Adult Services (OAAS) is responsible for approving and reporting permanent discharges from the waiver program to the Medicaid agency. No action can be taken to close the waiver case until approval is received.

**L-300- 400 RESERVED****L-500 ACTION ON CHANGES****Supplemental Security Income (SSI) Only**

Action on changes to SSI-Medicaid cases is taken only after notification from the Social Security Administration (SSA). The Medicaid agency receives information about changes to SSI records via the State Data Exchange (SDX) interface. Eligibility must be explored in other programs. If the enrollee is no longer eligible as a result of the change, send advance notice before closing the case.

Changes reported to the Medicaid agency which may affect eligibility of SSI cases should be sent to SSA via Form SSI.

**Nursing or ICF/ID Facility**

Upon receipt of the BHSF Form 148 from the LTC facility advising of the discharge of an enrollee, explore eligibility in all other programs. .

When an enrollee receiving a SSI payment while in a LTC facility is discharged to a non-institutionalized setting:

- Send adequate notice of the termination of vendor payment to the enrollee/responsible person and facility;
- Change the type case to a type for a non-institutionalized individual (Type case 78);
- Notify SSA of the discharge via Form SSI.

When an enrollee is discharged who is eligible for SSI payments but was not receiving them while in a LTC facility:

- Send adequate notice of the termination of vendor payment to the enrollee/responsible person and the facility;
- Change the type case to a type for a non-institutionalized individual (Type case 78, approval code 09); and
- Refer the enrollee/responsible person to SSA for cash benefits.

When an enrollee who is not SSI eligible is discharged to receive Medicaid-payable services in a medical facility, (for example, an acute care hospital or a rehabilitation center):

- Send adequate notice to the enrollee/responsible person and

the facility reporting:

- Termination of vendor payment to the LTC facility;
- Eligibility for medical services will end when the enrollee is discharged from the facility, unless the enrollee enters a LTC facility; and
- The enrollee/responsible person shall report discharge from the medical facility on the date of discharge.
- Review the enrollee's status at least monthly until discharge.
- When the enrollee is discharged from the medical facility and:
  - Is discharged back to a LTC facility, determine eligibility for vendor payment . Refer to [H-820, LTC MAGI-Related](#), or [H-830, LTC Non-MAGI Related](#);
  - Is discharged to a non-institutionalized setting, consider eligibility in all other programs. If ineligibility in all programs is established, send advanced notice of closure and close the case at expiration of the advance notice period.

When an enrollee, who is neither receiving nor \*\* eligible to receive SSI payments, is discharged from LTC facility:

- Send adequate notice of termination of vendor payment to the enrollee/responsible person, the facility, and OCDD or OAAS regional office (depending on type facility);
- Consider eligibility for Medicaid in other programs; and
- If ineligibility in all programs is established, send advance notice of closure, and close the case at the expiration of the advance notice period.

**Note:**

An enrollee between the ages of 21 and 65 is not eligible for Medicaid-payable services in a mental hospital.

**HCBS Only**

Upon receipt of notice advising of the discharge of a waiver enrollee, review the discharge to determine if it is a temporary absence of waiver services or a permanent discharge from the waiver program (loss of a waiver slot\*\*). OCDD or OAAS must make the determination of a permanent discharge from the waiver program \*\*.

### Temporary Absence from HCBS

When a waiver enrollee is temporarily discharged to a \*\* facility to receive Medicaid-payable services with the intent to return to HCBS:

- Give adequate notice, of the termination for waiver services to the enrollee/responsible person and the case management agency.  
\*\*
- Review the enrollee's status at least monthly, until discharge.
- Determine continued eligibility for medical assistance when the enrollee is discharged from the facility.
  - If discharged back to HCBS, determine eligibility in HCBS. Refer to [H-900 Home and Community-Based Services \(HCBS\)](#); and
  - If discharged to a non-institutionalized setting, consider eligibility in all other programs. If ineligibility in all programs is established, send advance notice of closure and close the case at expiration of the advance notice period.

#### **Note:**

Temporary absence may require the current type certification to be closed in the Medicaid Eligibility Data System (MEDS) to allow the enrollee to be certified in a different type certification. A discharge for temporary absence does not mean that the enrollee's eligibility for waiver services has been terminated. Permanent discharge (known as 'loss of a waiver slot') must be reported to the Medicaid agency by either the Office of Aging and Adult Services (OAAS) or the Office for Citizens with Developmental Disabilities (OCDD), depending on the waiver program.

### Permanent Discharge from HCBS:

When a waiver enrollee, who is receiving SSI payments and HCBS, is discharged by OCDD or OAAS and is eligible to remain in a non-institutionalized setting:

- Notify the enrollee/responsible person, the case management agency, and the OCDD or OAAS regional office (depending on

the waiver program) of termination of the waiver service payment for HCBS; and

- Change the type case to a type for a non-institutionalized individual (Type case 78).

When a waiver enrollee, who was not receiving SSI payments \*\* is discharged by OCDD or OAAS (depending on the waiver program) and is not eligible for SSI in a non-institutionalized setting:

- Send adequate notice of termination of waiver services payment to the enrollee/responsible person, the case management agency, and the OCDD or OAAS regional office (depending on the waiver program);
- Consider eligibility for Medicaid in other programs; and
- If ineligibility in all programs is established, send advance notice of closure and close the case at the expiration of the advance notice period.

**Note:**

An enrollee between the ages of 21 and 65 is not eligible for Medicaid-payable services in a mental hospital.

## L-600 ADEQUATE NOTICE

Adequate notice is sent no later than the date the action is taken.

The following case actions require only adequate notice:

- Closure upon death of the only enrollee or payee, when death has been verified (Form 148, copy of obituary, mail returned from post office marked "Deceased", or other reliable evidence), even if the actual date of death cannot be verified;
- Removal of enrollee upon death, if verified (see above);

**Note:** If death cannot be verified, advance notice is required before closure or removal.

- Closure, when the enrollee's whereabouts are unknown and agency mail directed to him has been returned by the post office indicating no known forwarding address;

**Exception:**

Do not terminate a child's eligibility before exploring \*\* continuous eligibility. Refer to [H-1910 Twelve \(12\) Months Continuous Eligibility](#).

- Closure when SDX provides information that the enrollee has moved out of the state, or it is documented that the enrollee has been certified in another state;
  - Removal of an enrollee from one case and certification in another case, with no change in benefits or an increase in benefits;
  - Increase or decrease in the amount of patient liability;
  - Addition of a recipient to a certification;
- \*\*
- Termination of vendor payment to a LTC Facility or case management agency, when other Medicaid benefits continue;

**Exception:**

When termination of vendor payment is the result of transfer of resource provisions, send advance notice.

- Open/close certifications (Notice of decision serves as the adequate notice);
- Mass changes that do not result in closure; or
- Changes that require advance notice of adverse action, when the enrollee waives, in writing, his right to advance notice.

**L-700      ADVANCE NOTICE**

All case changes that result in closure of Medicaid benefits and are not identified as requiring adequate notice, require advance notice.

**Advance notice gives the enrollee a specific period in which to:**

- Appeal the proposed action and have benefits continued until a fair hearing decision is made; or
- Provide verification that the change should not be made.

**Reminder:**

Twelve (12) months continuous eligibility for children under age 19

must be explored before terminating a child's eligibility. Refer to [H-1910 Twelve \(12\) Months Continuous Eligibility](#).

## **L-800 MASS CHANGES**

A mass change occurs when the federal or state government initiates a change in a program or a requirement that affects all cases with certain characteristics.

Mass changes include:

- Cost-of-living benefit adjustments (COLAs) for Retirement, Survivors, Disability Insurance (RSDI), SSI, and other federal benefits; and
- Changes in eligibility criteria based on legislative or regulatory actions.

## **L-900 APPEAL REQUESTS**

### **Adequate Notices**

If the enrollee requests a fair hearing after receipt of an adequate notice, do not reinstate benefits unless directed to do so by the Appeals section.

### **Advance Notices**

Do not take the proposed action if the enrollee requests a fair hearing during the advance notice period.