S-0000 VERIFICATION AND DOCUMENTATION

S-100 VERIFICATION

Verification is proof of an applicant/enrollee's statement regarding his circumstances.

Medicaid eligibility shall not be determined solely on the basis of declarations made by an applicant/enrollee.

Exception:

- Self-attestation of pregnancy and the expected date of delivery are acceptable from the applicant unless there is reason to believe that confirmation from a medical professional is required (i.e. multiple pregnancies with no recorded births on record).

- Self-attestation of Residency, Age, Household Composition, and Caretaker Relative status shall be accepted unless system checks for other factors reveal conflicting information.

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Rely to the maximum extent possible on electronic data matches, utilizing trusted third party data sources to confirm the self-attestations of income by the applicant/enrollee.

Self-attestation of Income

Self-attested income is unverified income information provided by the applicant/enrollee. Self-attested income is verified through the Federal Data Hub.

Accept the self-attested income amount if the reasonable compatibility standard is met when determining eligibility in Modified Adjusted Gross Income (MAGI) and non-MAGI determinations. If the difference in the attested income and data sources is greater than the threshold of 10 percent, then reasonable compatibility is not met.

"Reasonable compatibility" is a difference of no more than 10 percent between the self-attested income amount and the amount found in a systems check of data sources.

If the individual's self-attested income and the income found in a systems check are both above the Medicaid/MAGI eligibility level, the self-attested income amount is used without further verification. The individual will be determined ineligible and the account transferred to the Federally Facilitated Marketplace (FFM) for Advanced Premium Tax Credit (APTC) eligibility.

If the individual's self-attested income is above the Medicaid/MAGI level, but income found in the systems check puts the applicant below the Medicaid/MAGI eligibility level, the individual will be determined ineligible and the account transferred to FFM for APTC eligibility. If there is no database, self-attested income will be accepted.

If the individual's self-attested income and the income found in a systems check, are both below the Medicaid/MAGI eligibility level, use the self-attested income amount without further verification.

If the individual's self-attested income is below the Medicaid/Louisiana Children's Health Insurance Program (LaCHIP) MAGI eligibility level, but income found in the systems check is above the Medicaid/MAGI eligibility level, reasonable compatibility will be applied. If the difference is less than 10 percent, data is considered reasonably compatible and the individual will be determined eligible.

Exceptions:

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- Self-attestation of self-employment income that is below the eligibility limit is not acceptable. If the reported income is below the eligibility limit, it will be necessary to verify the self-employment income.

- When calculating the Patient Liability (PLI) for individuals certified in Long Term Care (LTC) programs, actual income and deductions should be verified in the post eligibility process.

Additional Verification is Required

If the individual's self-attested income is less than the income found in a systems check, but the difference between the two is 10 percent or

more, the reasonable compatibility standard is not met.

Request from the applicant/enrollee a reasonable explanation of the difference between self-attested income and income found through a system check. If the applicant/enrollee fails to provide a reasonable explanation, request verification of income.

Some examples of reasonable explanation to consider:

- Changed employer from Northern LA to Southern LA.
- Changed job position.
- Hours reduced due to illness/pregnancy.
- Job as student worker ended because no longer a student.

MAGI Tax Deductions

Obtain verification of any and all applicable deductions.

S-110 QUESTIONABLE INFORMATION

Verify all information that is questionable or when system information does not correspond to self-attestation, or exceeds the 10 percent reasonable compatibility standard for income, and the results affect potential or continued eligibility. The applicant/enrollee's statements on the application or renewal form, or during an interview, are questionable if they are: contradictory, do not correspond with information available through system interfaces, information contained in the Case Notes, Louisiana Medicaid Eligibility Determination System (LaMEDS), etc., or do not adequately explain the applicant/enrollee's circumstances.

Example 1:
Applicant/Enrollee states he is not employed, but income is showing in Louisiana Workforce Commission (LWC) Inquiry.

Example 2:
Applicant/Enrollee states he is not employed, but when contact is made with the household to speak with the applicant/enrollee, reply from household contact is that he is at work.

Allow the applicant/enrollee an opportunity to provide a reasonable explanation and/or resolve any discrepancy by providing documentary evidence or naming persons who can corroborate what they have said

(also known as a collateral contact). Documentary evidence, if available, is preferable to collateral contacts. If the applicant/enrollee refuses or fails to resolve any discrepancy, refer to G-1100 Cooperation.

S-120 DOCUMENTARY EVIDENCE

Documentary evidence is written confirmation of an applicant/enrollee's circumstances (e.g., check stubs, BHSF Employer form, BHSF Resource form, or insurance policies).
See *S-100 Verification* for the reliance on electronic data sources.

When original data sources are questionable, expand review to other available data sources. If data is insufficient to clear the discrepancy, obtain verification from the applicant/enrollee.

Accept any reasonable documentary evidence if the verification proves the statements of the applicant/enrollee as being accurate.

Use additional sources of verification if documentary evidence:

- Cannot be obtained, or
- Is not sufficient to make a determination of eligibility.

Documentary evidence is considered insufficient if it does not provide an accurate picture of the applicant/enrollee's situation, conflicts with other documentation, or appears to be falsified.

S-130 THIRD PARTY STATEMENTS/ COLLATERALS

Verbal confirmation from a knowledgeable source of an applicant's/enrollee's circumstances is allowed when expediting an application or renewal.

Most statements from applicants/enrollees are made on forms which explain the penalties for fraudulent statements. Confirm these statements with third-party sources (e.g., governmental or private agencies, and businesses) through documents, records, and phone calls.

The applicant/enrollee is entitled to know the name of the third-party

that provided verification information and its content.

Note:
Information provided by an individual (family member, neighbor) of an applicant/enrollee circumstances should only be used as a last resort.

S-140 ASSET VERIFICATION PROGRAM

Section 1940 of the Social Security Act requires state agencies to implement an Asset Verification Program (AVP) by which assets can be evaluated when determining eligibility for medical assistance. The AVP requirement states the agency must electronically obtain financial records from financial institutions with respect to an individual, his or her spouse, or any other person whose assets are required to be evaluated in connection with a determination for eligibility on the basis of age, blindness, or disability (non-MAGI), including long-term care services.

The AVP requires a non-MAGI related applicant/enrollee, his or her spouse or parent(s) to provide authorization for the State to obtain, on their behalf, any financial record held with an institution that will be used in evaluating eligibility for medical assistance. The Asset Verification Service (AVS) is used to verify liquid and real property assets when determining or renewing eligibility for non-MAGI programs. Effective August 1, 2019, LTC Programs began utilizing AVS data in eligibility determinations. The remaining non-MAGI programs began use of AVS data effective October 1, 2019.

S-140.1 Asset Verification Service (AVS)

The agency must have signed consent from any individual whose assets are reviewed in the eligibility process. The signature of the applicant/enrollee or authorized representative on the Medicaid application/renewal form is sufficient authorization to verify assets using AVS. If there is a legal spouse or parent(s) included in the resource unit, a signature must be obtained on an Authorization of Resource Verification form prior to requesting verification through AVS.

The authorization will remain in effect until the earliest of:

- The rendering of a final adverse decision on the applicant's application for medical assistance;

- The termination of the enrollee's eligibility for medical assistance;
- A break in Medicaid coverage that exceeds 30 days;
- The express revocation of the authorization in written notification to the State.

If an applicant, recipient, spouse, parent(s) or authorized representative refuses to provide, or revokes any authorization made for the State to obtain any records from any financial institution, the State may on that basis, determine that the applicant is ineligible for medical assistance, unless good cause exists.

Good Cause:

- Incapacitated individuals, e.g., comatose, not capable of acting on their behalf and do not have another person authorized to act on their behalf; or
- Spouse does not meet the definition of Community spouse, i.e., not living in the home, separated with no way to contact.

The Asset Verification Service is a requirement for all non-MAGI eligibility groups at application, renewal or when certain changes occur. Refer to G-0000 Application Processing, K-0000 Renewals and L-0000 Changes.

Verification of assets is a requirement **except** when:

- Self-attested total assets exceed the program limit;
- The individual is ineligible based on another factor;
- Considering for eligibility in the Family Opportunity Act Program;
- Renewing individuals eligible in a Supplemental Security Income (SSI) type case of assistance;
- Enrolled **only** in a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program; or
- Institutionalized individuals are in a MAGI category of assistance.

Verification should not routinely be requested. Self-attested resources and AVS reasonable compatibility rules shall be applied. Refer to the Procedures Manual for information on AVS reasonable compatibility rules.

S-150 RESERVED

S-160 PRUDENT PERSON

A prudent person is an individual who uses good judgment or common sense in handling practical matters.

The "prudent person" concept shall be used by the local eligibility worker in administering the Medicaid Program. In determining whether an eligibility worker has used the prudent person concept, the reasonableness of an action or decision must be viewed based upon his or her knowledge of and experience with the Medicaid program.

Eligibility staff must be prudent when the circumstances of a particular case indicate the need for further inquiry. Additional verification or substantiation should be obtained whenever the information provided by the applicant or enrollee is incomplete, unclear, or contradictory.

Circumstances which require a more thorough analysis include, but are not limited to, the following:

1. Documents, such as birth certificates, Social Security cards, etc., which appear to have been altered.

2. An individual who gives or has a history of providing conflicting or incomplete information.

3. An individual who appears to qualify for potential resources such as Social Security, unemployment benefits, veteran's benefits, medical insurance, etc., that have not been declared.

S-200 DOCUMENTATION

Documentation is the recording of information in the case record. Document all information required to:

- Make an eligibility decision, or

- Initiate a case change.

A properly documented case record allows anyone who reviews the Case Notes to make the same eligibility decision made by the agency representative. Documentation may be:

- On forms designed to record specific information,
- Original documents, photocopies, or signed statements, or
- Statements recorded in Case Notes.

S-210 CONVERSION OF WRITTEN RECORDS

Effective November 1, 2005, offices have the authority to convert written records (paper documentation) to electronic records and store them in the Electronic Case Record (ECR). It is extremely important that every page of the scanned image be viewed to confirm the accuracy and clarity of the scan prior to submission to the ECR.

Note:
See the Department of Health, Bureau of Legal Services, Legal Opinion Number 04-013 for reference to the legal authority under state law to convert written records to electronic records. In accordance with 42 C.F.R. § 431.17, the Centers for Medicare and Medicaid Services (CMS) has confirmed that the ECR storage system meets the requirements for maintenance of records.

With the implementation of LaMEDS, ECR was replaced with the Enterprise Data Management System (EDMS) and Case Notes effective 11/13/18. Documents previously stored in ECR can be viewed in EDMS.

S-210.1 Disposing of Paper Documentation after Converting to Enterprise Data Management System

All paper documentation, once scanned, verified and filed into the EDMS must be saved for a period of five (5) working days. After 5 working days has expired, the paper documentation can be shredded or otherwise properly disposed.