MA-2320 REDETERMINATION OF ELIGIBILITY
REISSUED 07/01/10 – CHANGE NO. 10-10

I. POLICY RULES

A complete redetermination of all eligibility factors subject to change is required as follows:

A. Categorically Needy - No Money Payment

Once every 12 months for M-AABD coverage groups with stable income evaluated under CNNMP regulations in MA-2100, Categorically Needy-No Money Payment.

Having no income or a pending application for benefits is not stable income. Such persons would have a redetermination once every 6 months.

B. Medically Needy

Once every 6 months for M-AABD coverage groups evaluated under MN regulations in MA-2120, Medically Needy Regulations.

1. Re-enroll in deductible status:

   a. All Medically Needy cases for a consecutive 6 month certification period if all eligibility requirements continue to be met, and

   b. The deductible

      (1) Was met in the previous certification period, or

      (2) Is expected to be met in the next certification period. A reenrollment must be conducted to determine if the deductible is expected to be met in the next certification period.

      If a case is authorized for meeting the deductible in the previous certification and the case has a deductible in the new certification period, send the recipient a timely notice for the new deductible.

2. Propose termination using timely notice:

   a. If the case is ineligible in any other aid program category, and

   b. If the previous deductible was not met and there is no indication that the deductible can be met in the next certification period.

(I.B.2.b)

(1) If the recipient provides evidence within 10 workdays that the deductible was met or will be met within the certification period, do a complete re-enrollment of eligibility for the next certification period.

(2) If the recipient provides evidence after 10 workdays that the deductible was met, but before the 10th day of the following month, refer to reopen policy in MA-2304, Processing the Application.

3. Prior to termination, evaluate each individual in the case in other aid program/categories for ongoing benefits.

C. Medicare Coverage Groups

Once every 12 months for MQB-Q, MQB-B, and MWD groups evaluated under regulations in MA-2130, Qualified Medicare Beneficiaries - Q and MA-2140, Qualified Medicare Beneficiaries – B, and MA-2150, Medicaid – Working Disabled.

II. ITEMS TO BE VERIFIED AT REDETERMINATION

A. Verify the following eligibility requirements at every redetermination and document the case file.

Requirements	References
1. Living Arrangement	MA-2510
2. Resources	MA-2230
3. Transfer of Resources	MA-2240
4. Income	MA-2250
5. Need/Financial Responsibility	MA-2260, MA-2261, MA-2270
6. Disability, when applicable	MA-2525
7. Blindness, when applicable	MA-2530
8. Unmet Medical Needs	MA-2270
9. Alien status	MA-2504

1. The status of qualified aliens lawfully residing in the United States.

a. Verify the individual continues to reside lawfully in the United States using SAVE, Systematic Alien Verification for Entitlement Program. Follow procedures in EIS 1108, SAVE Verification Information System. The case file contains a copy of documentation provided at application and may be used.

(II.A.1.)

b. DO NOT use SAVE as verification for trafficking victims. The case file contains a copy of the ORR certification letter received at application. Call the trafficking verification line at (202) 401-5510 to confirm the validity of the certification letter or eligibility letter for children if questionable.

c. If the record contains expired document and the individual is unable to present any immigration documentation evidencing his alien status, refer the applicant to the local USCIS Office to obtain documentation of his immigration status.

B. Items verified only if there is a change:

1. Residence
2. Age
3. Kinship
4. Death of a parent
5. Citizenship/Identity

Citizenship and identity documentation is required at application and does not need to be re-established at redetermination. See VI. Below for exceptions and when a case record may not contain documentation.

III. THE REDETERMINATION INTERVIEW

A. Scheduling the Review

Begin the redetermination in time for the timely notice to be effective prior to expiration of the certification period.

1. Send the review notice, DSS-8189, Appointment Notice, that is generated by EIS to the recipient to schedule the review.

   NOTE: The review notice is generated two months prior to the end of the certification period.

2. Retain a copy of the review notice in the case record.

B. Steps in the Redetermination Process

1. Explain that the recipient/representative must cooperate in establishing eligibility and failure to cooperate is a reason for termination. (Refer to IV., below.)

2. Discuss the b.u.'s current situation and remind the recipient/representative of his rights and responsibilities. (Refer to IV. through XVI., below.)

3. Have the recipient sign a release of information and explain that it will be necessary to contact certain people, such as employers, landlords, and others who may have knowledge of his situation.

(III.B.)

4. If assistance is based on disability or blindness and new medical information is necessary, explain that it will be necessary for a physician to complete a medical report. If this report is not returned to the agency within thirty days of the date of the interview, the case will be closed for failure to cooperate. If the recipient is mentally or physically unable to have the form completed, the IMC must assist him.

5. Inform the recipient/representative that he will be notified of any changes to be made in his medical assistance following the redetermination.

   NOTE: Instruct homeless individuals with no permanent address to come to the agency to pick up their ID card and necessary notices. Attach notices of review/redetermination to their ID card. If the client fails to pick up his ID card for two consecutive months, propose termination for inability to locate.

IV. COOPERATING WITH THE COUNTY DSS

A. Inform the recipient/representative that he is responsible for cooperating with the county dss in providing information necessary for determining continuing eligibility.

B. Remind the recipient/representative that he is responsible for the following:

1. Providing the necessary information within a reasonable period of time to determine eligibility. For example, he must inform the county of any b.u. member's employment and provide wage stubs or names of collateral sources to verify this information.

2. Providing medical bills for incurred expenses when he has a deductible. Explain the consequences of an unmet deductible.

3. Reporting within 10 calendar days to the county dss any change in situation such as an increase or decrease in income, change in address, employment, people living in the household, inheritances, and other sums of money. Explain that failure to report a change in situation may lead to the recipient having to repay assistance received in error or being tried for fraud by the courts and receiving whatever penalty is imposed as a result of that trial. Explain to the recipient/representative the meaning of "fraud".

4. Informing the county dss of any health insurance he has or any accidents in which he is involved.

   a. Examples of the kinds of insurance that must pay the medical bills or refund the Division of Medical Assistance are health insurance, auto insurance settlements used to pay medical bills, worker's compensation, Champus or Tri-Care, and indemnity policies.

(III.B.4.)

b. Explain that:

(1) The above is required because, by accepting Medicaid, the recipient has given the state the right to all money that he might be entitled to from all insurance that will pay for his medical expenses up to the amount paid by Medicaid.

(2) It is a misdemeanor for anyone to willfully fail to tell the county dss of any claim he may have against anyone for medical expenses, regardless of the kind of insurance or accident involved.

V. ENUMERATION REQUIREMENT

A. Inform the recipient that the provision of or application for a Social Security number (SSN) is a condition of eligibility for Medicaid.

B. If a recipient cannot provide his Social Security card because he has not been issued one or he does not know his SSN and he wishes to apply for a SSN, refer to MA-2450, Enumeration Procedures. Assistance may not be denied or delayed pending issuance or verification of an SSN.

C. Explain that the recipient's SSN's will be used to match information with other agencies such as the Internal Revenue Service, Social Security Administration, and Employment Security Commission. Inform him that the matches will be done unless he requests termination of his assistance.

VI. U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION

Citizenship and identity documentation is required at application and does not need to be re-established at redetermination.

Review the case record(s) due for review for citizenship and identity documentation. Conduct an SOLQ social security number inquiry for each applicant or recipient at re-enrollment. If evidence is needed at redetermination, contact the recipient using the DMA-5097, DMA-5097s, Request for Information. Begin the redetermination process in case the documents are received.

There are a few exceptions when the case record may not contain citizenship documentation at redetermination.

(VI.)

A. North Carolina Health Choice Children

1. The citizenship/identity documentation requirement does not apply to North Carolina Health Choice (NCHC) recipients who applied prior to January 1, 2010. NCHC recipients who applied prior to January 1, 2010 and did not provide documentation of citizenship have a C/I code 98 in EIS. At redetermination, citizenship does not have to be established for these individuals who continue to be NCHC eligible. Complete the redetermination and continue to use C/I code 98.

   Note: If the individual terminates, at reapplication citizenship documentation is required.

2. If a NCHC recipient who applied prior to January 1, 2010 and has a C/I code of 98 changes from NCHC to Medicaid at redetermination, citizenship/identity documentation must be provided. Contact the recipient using the DMA-5097, DMA-5097s, Request for Information.

   a. If the recipient has the documents to provide citizenship and/or identity evidence, obtain them. Make copies, document the record, and complete the re-determination. Return the original documents to the recipient.

   b. If the recipient states he does not have documentation and is making a good faith effort to obtain the needed documents, document the record. If all other eligibility requirements are met, complete the redetermination and authorize with the appropriate certification period. Retain the C/I code 98 and use Special Review Code "Z" on the DSS 8125 to follow up on the status of obtaining the documents. Use the third month of the new certification period for the date. A message will show on the Case Management Report to remind the worker citizenship and/or identity documentation is needed. (See EIS 4000, Codes Appendix.)

   c. Contact the third party source or the recipient to determine status of obtaining the documents.

   d. Continue to use Special Review Code "Z" for another 3 months. Continue to contact the recipient every 3 months or until the end of the certification period, provided:

      (1) The recipient has not yet provided documents but continues to make a good faith effort to obtain the documents, or

      (2) The county has not received documentation or a response from an inquiry made to assist the client.

(VI.A.2.d.)

(3) Terminate at any time when a response is received indicating that no documentation confirming citizenship/identity is found or the recipient is not continuing a good faith effort to obtain the documents or provide the county with information needed to assist in obtaining documentation.

e. If documentation confirming citizenship/identity is not provided by or at the end of the certification period, complete the DSS 8125, update the C/I code to C/I code 97 with the date the first DMA-5097 was sent requesting the documentation. Terminate the case effective the last day of the current certification period. The individual has received reasonable opportunity to provide documentation of citizenship/identity and must provide documentation confirming citizenship/identity at reapplication.

f. If the recipient cannot obtain the necessary documents, requests help, or has special needs demonstrating a need for assistance and lacks someone who can act on his behalf, the county must assist the recipient in acquiring the documents including cost involved. Vital Records requires an authorization from the recipient, parent or legal guardian to provide a certified copy to the county. Use MA-2506, Figure 3, U.S. Citizenship Documentation Birth Certificate Request. Instructions on obtaining a certified birth certificate are on the Vital Records web site, http://vitalrecords.dhhs.state.nc.us/vr/index.html.

B. Exceptions to Providing Further Citizenship Documentation at Redetermination

Do not require further citizenship/ identity documentation at redetermination for the following:

1. Title IV-E and Title IV-B children. See MA-3230, Eligibility of Individuals Under Age 21, for procedures to obtain the necessary documentation of Title IV-B or Title IV-E status at redetermination.

2. Children born in the United States whose delivery was covered by Medicaid.

3. Current or former SSI recipient. Use OLV to access the SDX to prove current or former SSI status.

4. Current or former Social Security Disability Insurance (SSDI) recipient, or Medicare recipient. Use OLV to access SOLQ to prove current or former Medicare and SSDI status.

5. Current or former lawful permanent resident (LPR). Refer to MA-2504, Alien Requirements, Figure 2 for acceptable documentation for LPR applicants and use SAVE, Systematic Alien Verification for Entitlement Program, to verify the authenticity of the LPR document.

   Print the screen with the evidentiary information and put in the Citizenship/Identity Documentation sub-folder in the recipient's permanent record.

C. Ex Parte

1. Use OLV to document citizenship and identity for current or former SSI and Medicare recipients. Use SDX to document citizenship and identity for former SSI recipients. Use SOLQ to document citizenship and identity for current or former SSDI and Medicare recipients. Continue to use C/I code 50.

2. If the individual is changing programs and an 8124 is required, a SSA data match is completed.

VII. INFORMING THE RECIPIENT/REPRESENTATIVE OF HIS RIGHTS AND RESPONSIBILITIES

Review recipient/representative rights and responsibilities concerning Medicaid and the medical services available.

Emphasize the following points:

A. Information given to the agency is confidential.

B. The individual has the right to withdraw from the Medicaid program or the application process at any time.

C. Based on the rules in MA-2350, Certification and Authorization, explain that he can continue to be certified for Medicaid if found eligible. Explain the concept(s) of deductible or patient's monthly liability, if applicable.

D. He has the right to reapply at any time if found ineligible or his case is terminated.

E. He has the right, following a local appeal, to appeal within the appropriate time limit to the Division of Social Services (Refer to MA-2420, Notice and Hearings Process.) if;

1. Medicaid is terminated, or
2. He disagrees with having a deductible or patient monthly liability, or
3. He believes the amount of his deductible or patient monthly liability is incorrect, or
4. He believes the county dss is delaying action in investigating his request for a review of his circumstances.

VIII. TRANSFER OF RESOURCES

Inform the recipient that if he, his legal representative, or financially responsible spouse transfers any real property, personal property or any other resources, including resources counted or excluded in determining Medicaid eligibility, for less than current market value, the transfer may result in a period of ineligibility for Medicaid payment of cost of care for institutional services. Refer to MA-2240, Transfer of Resources.

IX. PROTECTION AGAINST DISCRIMINATION

Explain the protection against discrimination on the grounds of race, creed or national origin by Title VI of the Civil Rights Act of 1964.

X. FAMILY PLANNING WAIVER (FPW)

A. Explain Family Planning Services to payees of individuals of childbearing age (including minors, both male and female who can be considered to be sexually active) who desire such services. See Family Services Manual, Volume VII, Health Support Services, Chapter 3, for additional information.

B. If Family Planning Services are desired, referral to the Services Unit must be made.

XI. HEALTH CHECK PROGRAM

Health Check pays for health care for children (newborns through age 20) who are authorized for Medicaid in any aid program/category, except MQB and those who receive emergency Medicaid only. See MA-2301, Conducting a Face-to-Face Intake Interview, for instructions on explaining the Health Check program.

XII. COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS (CCNC/CA)

CCNC/CA are managed health care programs for Medicaid and North Carolina Health Choice (NCHC) recipients. The county dss must either enroll recipients in CCNC/CA or exempt recipients at application; redetermination or any time a recipient contacts the agency to request a change in CCNC/CA enrollment status. For those recipients who are not enrolled, follow the procedures below. Refer to MA-2425 for CCNC/CA policy.

A. Face-to-Face, Group, and Telephone Reviews

1. The county DSS must enroll recipients in CCNC/CA or exempt recipients as defined in this policy. The county DSS must enroll all recipients who are mandatory in CCNC/CA at application, redetermination, or any time a recipient contacts the agency to request a change in CCNC/CA enrollment status. The DMA-9016, CCNC/CA: The Benefits of Being a Member-Medicaid, must be explained to all recipients who are mandatory and optional at application, redetermination, or anytime a recipient contacts the agency to request a change in CCNC/CA enrollment status. **Enrollment must be offered. Do not automatically exempt a recipient in an optional group.** Refer to MA-2425, CCNC/CA, VII. B. and C. to determine who is Mandatory, Optional, or Ineligible.

2. Provide each recipient with a list of CCNC/CA primary care providers (PCP). Do not include the PCP's provider number on this list.

(XII.A.)

3. Make every effort to help the recipient choose a doctor for each person during the interview based on the provider availability, restrictions, and medical needs.

4. If the recipient cannot choose or refuses to choose a PCP (and is not otherwise exempt), choose a PCP for each recipient based on his enrollment history, location of residence, and type of care. In addition, verify the provider availability and restrictions. Refer to MA-2425, VII. A.

5. Complete the Carolina ACCESS Enrollment Form for Recipients of Medicaid and Health Choice, **(DMA- 9006)** for all Medicaid and North Carolina Health Choice (NCHC) recipients and file in the case record. If exempt, complete the form with the appropriate exemption code and file in the case record.

6. Educate the recipient using the CCNC/CA Member Handbook.

For questions regarding CCNC/CA contact your Medicaid Program Representative.

B. Pregnancy Medical Home (PMH)

Explain the benefits of choosing a Pregnancy Medical Home (PMH) and, if not already participating, give a copy of the PMH handout at each redetermination to each pregnant Medicaid recipient. Assist the pregnant Medicaid recipient in choosing a PMH. Refer to MA-2301, VI.B. Conducting A Face-To-Face Interview, for PMH instructions.

XIII. MEDICAL TRANSPORTATION

Inform the recipient at each review that he is entitled to help from the agency in arranging and/or paying for medical transportation when he is authorized for Medicaid, except for limited MQB coverage and NCHC. Give each recipient the DMA-5046, Medical Transportation Assistance Notice of Rights, and explain the provisions in MA-2910, Medicaid Transportation.

XIV. EXPLAIN THE FOOD AND NUTRITION SERVICES PROGRAM

Inform the recipient of the Food and Nutrition Services Program offered by the department and the procedures for applying for food stamps.

A. If he wishes to apply, initiate the required action.

B. If he receives food stamps, the Medicaid staff must provide information requested by the Food and Nutrition Services Program staff, i.e., deductible information, copy of the DMA-5036, Record of Medical Expenses Applied to the Deductible, etc.

XV. EXPLAIN THE WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM

A. Types of Services

1. Explain the availability of benefits through WIC.

   This program provides a nutritional supplement to the following:

   a. Pregnant women during pregnancy and up to six months after delivery, and breastfeeding women up to one year after the baby is born, and

   b. Infants up to age one, and

   c. Children up to age 5.

2. Explain that nutritional counseling is available through the WIC Program.

B. Referral To The WIC Program When Services Are Desired

1. If services are desired, the IMC must make a referral to the WIC Program at the Local WIC Agency.

2. Provide the recipient a WIC brochure, titled "A Healthy Start."

XVI. OTHER AVAILABLE SERVICES

A. Explain other services available within the department and make a referral for any services requested.

B. Explain the Use of the Medicaid Identification Card (MID). Refer to MA-2380, Medicaid Identification Card.

1. Explain that a gray Medicaid Identification (MID) card is issued yearly, and that a new card is issued only when there is a change in the PCP, a legal name change, or when the card is lost, destroyed, or stolen.

2. Make sure he understands that the MID is not proof of Medicaid eligibility. See MA-2380, Medicaid Identification Card.

3. Remind him of his responsibility in using the ID card only for eligible members and that he must take the card with him, along with other ID for adults and any other insurance cards including Medicare, when requesting services.

4. Tell him he must sign the card, and that if he becomes ineligible for Medicaid he should not throw away the card. He may become eligible again and need the card.

XVII. REDETERMINATION/VERIFICATION FORMS

A. Completing the Forms

One redetermination/verification form can be used for a redetermination and a six month review as follows:

1. Every item on the base document (DMA-5008/5007) subject to change must continue to be reviewed at each redetermination of eligibility.

2. If there has been no change in an item since initial eligibility or the last redetermination of eligibility, enter in red ink above the initial entry NC (No change) and verification that no change has occurred. Do not line through the initial entry.

B. If a change has occurred in an item since initial eligibility, enter above the initial entry in red ink the new information and verification. Do not line through the initial entry.

C. Upon completing the form, review it again with the recipient/ representative to be sure that he understood the questions and the IMC understood his responses. When reviewing the form, ask for items that may be needed for verification. For example, he may have wage receipts or Social Security award letters.

D. For a redetermination when a recipient is placed in LTC outside of his county of residence**.**

1. Send a DMA-5007 to the second county DSS to obtain the recipient's/ representative's signature. (If the representative lives in the recipient's county of residence, it is not necessary to contact the second county.) Attach a photocopy of the base document and of the most recent DMA-5007. The second county must indicate any changes on the new DMA-5007 before it is signed and must verify the patient's personal needs account at the facility.

2. If a recipient is in a public institution and there is no representative in the county of residence, request the information needed to complete the DMA-5007 from the institution. Remember to request information about the patient's personal needs account. Do not send the original base document to the facility. Request only the recipient's/representative's signature on the DMA-5007. This 5007 is to be completed by the IMC based on information provided by the institution.

E. The recipient/representative must sign the redetermination form in red ink above the initial signature to indicate that all the answers are true to the best of his knowledge, he understands that willfully supplying incorrect information could cause him to be charged with fraud, and that he authorizes the investigation of his eligibility for assistance by county dss, state officials, and federal officials.

F. The IMC must sign his name and date in red ink above the initial signature and date.

XVIII. COLLATERAL CONTACTS

Collateral sources are used to substantiate or verify information necessary to establish eligibility. Collateral sources include specific individuals, business organizations, public records, and documentary evidence.

A. Limit collateral contacts to those necessary to obtain the required valid information. Specific collaterals necessary for verification are outlined in the eligibility determination sections.

B. If the recipient/representative does not want you to contact necessary collaterals, ask him to sign a statement requesting termination of his assistance or terminate his case due to failure to cooperate.

C. Record the verifications on the redetermination/verification form.

D. Review and document discussion of household composition for all categories to see if there are additional persons who should be in b.u. or if some members of the b.u. should be deleted. Verify all eligibility factors for additional members applying for Medicaid.

XIX. HOME VISIT

Home visits may be made at the discretion of the county dss. Counties are encouraged to establish local written policy setting forth basic premises for use of the home visit as a management tool. Visits are useful in corrective action for error prone cases, usually those with earned income or assets near the maximum level. If a visit is planned, it must be announced.

XX. ACTIONS REQUIRED AT THE END OF CERTIFICATION PERIOD

A. The Redetermination Is Completed Timely

1. If the case remains eligible follow instructions in EIS to authorize a new c.p.

2. If a change benefits the recipient, send an adequate notice regarding the change and follow instructions in EIS to authorize a new c.p.

3. If a change adversely affects the recipient, send a timely notice. The notice must expire in time to key the change by pull-check. Follow instructions in EIS to make the change. If notice does not expire by pull-check refer to C. below for instructions.

B. Recipient Fails To Complete The Redetermination Process

1. Send a timely notice to terminate.

2. If the timely notice expires after pull-check, benefits must continue for cases in authorized status. The IMC must authorize one month c.p. until timely notice to terminate expires. Follow instructions in EIS 3051, Redetermining Eligibility for Medicaid Programs.

REISSUED 03/01/11– CHANGE NO. 03-11

(XX)

C. Redetermination Not Completed By The End Of The C.P.

NOTE: The county is expected to complete work in a timely manner.

1. A one month c.p. must be authorized in EIS if the IMC fails to complete the redetermination prior to end of c.p. and fails to send timely notice allowing termination to be keyed prior to pull-check in the last month of the c.p.

2. If the redetermination is completed after extending the certification period for a month and case remains eligible, IMC will use the one month c.p. as the first month of the new c.p.

3. Refer to MA-2270, Long Term Care Need and Budgeting, for changes in PML's.

XXI. REDETERMINATION ALTERNATIVES

A. The following methods for completing reviews have been developed as suggested alternatives to the one-on-one interview:

1. Group Interview
2. Telephone Call
3. Mail

B. The recipient must be notified and agree to the alternative method of completing the review. Refer to D.2. below for scheduling the review.

C. Selection of Cases for Alternative Review

1. Determining When a Review is Due

   Start the process in the 4th month of a 6th month coverage period or the 10th month of a 12 month coverage period.

2. Selection of Individuals to Participate

   Once you have determined those individuals due for a review, you must determine the best candidates to participate in the alternative methods of completing the review.

   a. Screening and Selecting Cases

      (1) Review the case record(s) to determine if the recipient can read, write and function with minimal supervision.

(XXI.C.2.a)

(2) Look at previous signature, educational level and other problems noted in the record that would prevent the recipient from participating in one of the alternate methods for completing reviews. For example, if the recipient signed the previous review forms with an "X", this indicates that the individual may be unable to write. Also, if the educational level is documented in the record as being ninth grade or below, the recipient MAY NOT be a good candidate for the alternate review.

(3) If the IMC is unsure whether to include the recipient in one of the alternative methods for completing reviews, ask for input from the supervisor.

b. Include the following categories in the group interview:

(1) CNNMP recipients, and
(2) Deductible cases,

c. Exclude the following:

(1) LTC population, except when a representative is noted in the record, and

(2) Dual Aid/Program category cases, example MAABD/MQB

D. Setting Up The Alternative Review/Redetermination

1. Once cases have been identified that are due for a review and the method of completing the review has been selected, the IMC must:

a. Review the case record(s) to determine items needed to complete the review, including the reserve history sheet.

b. Complete the following checks prior to the review:

(1) On-line computer matches,

(2) Property checks, and

(3) Records at the clerk of court.

2. Scheduling The Review

a. Send the review notice DSS-8189, Appointment Notice, to schedule the review.

(1) Notify the recipient on the notice how the review will be completed and that he can decline the review being completed by the alternative method but he must notify the IMC within 5 workdays of his decision not to participate.

(XXI.D.2.a)

(2) Notify the recipient of items needed to complete the review.

(3) State the time and place on the notice or the scheduled time you will call to complete the review or when the self complete form must be returned.

b. Reserve conference room if a group interview.

E. The Group Review/Redetermination

1. Setting up the Group Review

a. Arrange for one IMC to be the facilitator of the group and one IMC to monitor the group.
b. Allow at least 1-1/2 hours to complete the group interview.

c. It is suggested that you schedule no more than 25 people for the group interview.

2. Procedures

a. The Interview

(1) Start the review no later than 15 minutes from the appointed time.

(2) Explain to the group that the information they give is personal and should be kept confidential. Any questions that are specific in nature should be held until the end of the session and will be discussed individually and answered at that time.

(3) Refer to III. through XVIII. above for detailed information that should be addressed during the group interview.

b. Completion of the Group Interview

(1) At the end of the group session, check each review form to insure all questions have been answered and no additional items are necessary to complete the review before the recipient leaves the interview.

(2) Answer any questions that are specific to a case in a private one-on-one situation.

(a) Send a timely notice to the recipient notifying of the termination for Medicaid.

(b) Refer to the appropriate section for notice requirements and procedures.

(XXI.E.2)

c. Documentation

Document the case record when:

(1) The recipient failed to show up for the review.

(2) You have determined that the situation has not changed. Send the appropriate notice.

(3) You have determined that the situation has changed. Send the appropriate notice.

(4) The recipient failed to provide information which is his responsibility or when collaterals failed to respond to request for information by deadline. Send the appropriate notice.

F. The Telephone Call Review

1. Steps in Setting up the Telephone Interview

The telephone review can be accomplished in two ways. One by sending the review notice to the client and letting the recipient complete the form while telephone interview is being completed or the IMC can keep the review form and complete the review form while interviewing the recipient on the telephone.

a. Review the case record(s) to identify items needed to complete the review, including the reserve history sheet.

b. Send the review notice, DSS-8189, Appointment Notice, review form (if the recipient is completing the form) and a self addressed envelope to the recipient to schedule the telephone review.

NOTE: State the time on the notice that you will call the recipient to complete the telephone interview. Notify the recipient on the notice that the review will be completed by telephone and allow the recipient the opportunity to decline the review being completed by a telephone call or to change the time of the telephone review.

c. Notify the recipient of items needed to complete the review. Use the DMA-5097/5097S, Request for Information. If the information is not received, send a timely notice. The case will be terminated for Medicaid after the timely notice is sent.

(XXI.F.2.)

2. Conducting the Telephone Interview

All items necessary for completing the telephone interview should be present before calling the recipient for the telephone review.

a. Procedures

(1) Call the recipient at the appointed time.

(2) Refer to III. through XVIII. above for detailed information that should be addressed during the telephone interview.

b. Completion of the Telephone Review

(1) If the recipient completed the review form, ask the recipient to sign the review form and mail the form in the self addressed envelope within ten workdays or the case will be terminated for Medicaid.

(2) If the IMC completed the review form, notify the recipient that he will receive the review form in the mail and he must sign the form and return the form within ten workdays or the case will be terminated for Medicaid.

c. Documentation

Document the case record when:

(1) The recipient fails to keep the telephone review appointment.

(a) Send a timely notice to the recipient notifying of the termination for Medicaid.

(b) Refer to the appropriate section for notice requirements and procedures.

(2) You have determined that the situation has not changed. Send the appropriate notice.

(3) You have determined that the situation has changed. Send the appropriate notice.

(4) The recipient failed to provide information which is his responsibility or when collaterals failed to respond to request for information by deadline. Send the appropriate notice.

(XXI.)

G. Redetermination by Mail

At county option, the DMA-5007MR may be used for mail reviews of Aged, Blind and Disabled Medicaid eligibility when the assistance unit is authorized without a deductible.

1. Criteria for Selecting Cases Reviewed by Mail

a. Cases reviewed by mail must be one of the following:

(1) PLA MAABD(N) Cases

(2) All Non-SSI LTC Cases

(3) MQB-Q and MQB-B Cases -- authorized for MQB which have not met a deductible for MAABD in the last past six months and which have not submitted enough bills to indicate the current deductible will be met.

AND

b. Must meet all of the following criteria:

(1) Only source of income is predictable (RSDI, VA, Civil Service Retirement, NC State Retirement, etc.).

(2) The a/r does not have to meet a deductible (may have a PML if LTC).

(3) Total countable assets at last determination of eligibility were $1,700 or less.

(4) All match reports (including FRR) have been verified and considered.

(5) Assets are not questionable due to an unsettled estate or due to alleged incompetence.

c. Do not include the following types of cases:

(1) MAABD-MN cases with a deductible

(2) MQB cases which meet the deductible and transfer to MAABD-Q/B

(3) Cases with unstable unearned income or rental property

(4) Cases with earned income (wages, etc.)

(5) Cases in which the casehead is known to be illiterate, or does not speak English and does not have an authorized representative that acts for the recipient.

(6) SSI cases (not reviewed)

(XXI.G.)

2. Preparation for Mail Review

   a. Identify cases to be included which meet the criteria in G.1., above.

   b. Initiate verifications

      (1) Review the most current case information to identify verifications needed to complete the review, including reserve history sheet. Remember to update the reserve history sheet if there is a change.

      (2) Request needed third party verifications.

   c. Date of the letter (date the form will be mailed).

3. Complete the cover page of the DMA-5007MR with the following:

   a. Name and address of person expected to complete the form (either the recipient, or if he cannot complete the review, his representative).

   b. Check each block which applies to information or verifications needed and write in any other information needed from the client not listed.

   c. "Return No Later" date—should be ten work days from the date the form is mailed to the casehead. This is the date that the form must be returned signed with all items completed.

   d. Include the following with the form:

      (1) Release of information to be signed and returned, and

      (2) A pre-addressed return envelope. Write or stamp "Review or Re-enrollment" and the IMC's name on the envelope, and

      (3) Telephone number where the IMC can be reached.

4. Contact the recipient or his representative.

   a. Mail contact, followed by telephone contact:

      (1) Send DMA-5007MR to the recipient or representative no later than the first work day of the fifth/eleventh month of the current certification period; and

(XXI.G.4 a.)

(2) Contact the recipient or representative by phone when the DMA-5007MR is returned to the dss. Explain the services available. Make at least two attempts to reach the recipient or representative by phone on two different days. If unsuccessful, request any needed information or clarification by mail, attaching a notice of proposed termination, giving ten work days to provide the information.

OR

b. Complete the form during a telephone interview and mail for signature on the same day the interview is conducted.

5. To comply with the review requirements, the casehead/representative must:

a. Return requested information.

b. Provide a current telephone number where the recipient or representative may be reached during the daytime.

c. Name all current members of the PLA recipient's household.

d. Provide information regarding unmet medical expenses of the LTC recipient and income of the community spouse.

e. Read their rights and responsibilities information and sign the form. When the telephone contact is made, the worker should ask specifically about services and explain this section of the form.

f. Either return the form to the county dss no later than the date indicated on the cover letter of the DMA-5007MR or contact the county for an appointment to conduct the review in person.

6. Propose termination of the case using a timely notice if:

a. The client or the representative does not respond either by returning the DMA-5007MR by the "Return No Later" date, or by contacting dss (by phone, letter, or in person) to request an interview by that date. Do not send another form. An automated timely notice can be used for proposed termination notice.

OR

(XXI.G.6)

b. The form when returned is not signed, is incomplete, or information is missing which the IMC requested on the DMA-5007MR and which cannot be obtained any other way. Copy the form for your record and re-mail original with a manual timely notice attached, proposing termination unless it is completed, signed, and returned within ten (10) work days.

OR

c. Ineligibility is established. Send an automated timely notice.

OR

d. The client requests an interview, but does not keep the appointment. Send an automated timely notice.

XXII. REVIEW CHARTS

Updating the Eligibility File

A. Use Chart 1 to determine when to update the eligibility file to reflect a completed redetermination for LTC cases (excluding SSI), MN cases and CN-NMP cases with unstable income.

Update by the cut-off date indicated on the DATA PROCESSING SCHEDULE FOR CHECKS AND I.D. CARDS:

Certification Period	Cut-off Month
January – June	June
February – July	July
March – August	August
April – September	September
May – October	October
June – November	November
July – December	December
August – January	January
September – February	February
October – March	March
November – April	April
December – May	May

CHART 1

(XXII.)

B. Use Chart 2 to determine when to update the eligibility file to reflect a redetermination for PLA CN-NMP and MQB cases with stable income.

Update by the cut-off date indicated on the DATA PROCESSING SCHEDULE FOR CHECKS AND I.D. CARDS:

Certification Period	Cut-off Month
January – December	December
February – January	January
March – February	February
April – March	March
May – April	April
June – May	May
July – June	June
August – July	July
September – August	August
October – September	September
November – October	October
December – November	November

CHART 2