
RE-ENROLLMENT

**MA-3420 RE-ENROLLMENT
REVISED 07/01/10 – CHANGE NO. 06-10**

I. BACKGROUND

Federal regulations require that eligibility be evaluated periodically. This section provides re-enrollment procedures. Re-enrollments are to be completed promptly to ensure ongoing benefits are issued timely and accurately.

II. POLICY PRINCIPLES

A. Complete a re-enrollment according to the aid program/category prior to pull date in the last month of the certification period.

1. Complete a re-enrollment every 12 months for MIC, NCHC, MAF-D, and MAF-C. The MAF-C case cannot include a caretaker over age 18.
2. Complete a re-enrollment every 6 months for MAF-N, MAF-M, HSF-N or HSF-M and MAF-C when the case includes a caretaker over 18.
3. Complete a re-enrollment for newborns prior to the end of the one year automatic newborn period.
4. Complete a re-enrollment for an MPW case prior to the end of the postpartum period. Follow policy in this section for an MAF-N re-enrollment.

B. Begin the re-enrollment process in time to allow a timely notice period to expire prior to pull date in the last month of the certification period.

C. Reverify only those eligibility factors that are subject to change, such as income, household composition, resources, and the status of qualified aliens lawfully residing in the United States.

1. 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.
2. 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.
3. 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.

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(II.)

- D. Do not reverify factors that are not subject to change, such as date of birth or citizenship. 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.

1. North Carolina Health Choice Children

- a. 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.

- b. 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.
- (1) 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.

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(II.D.1.b.)

- (2) 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.)
- (3) Contact the third party source or the recipient to determine status of obtaining the documents.
- (4) 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:
 - (a) The recipient has not yet provided documents but continues to make a good faith effort to obtain the documents, or
 - (b) The county has not received documentation or a response from an inquiry made to assist the client.
 - (c) 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.
- c. 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.
- d. 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.

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(II.D.)

2. Do not require further citizenship/ identity documentation at redetermination for the following:
 - a. 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.
 - b. Children born in the United States whose delivery was covered by Medicaid.
 - c. Current or former SSI recipient. Use OLV to access the SDX to prove current or former SSI status.
 - d. 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.
 - e. Current or former lawful permanent resident (LPR). Refer to [MA-3330](#), 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.

E. 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.

F. Terminate the case at the end of the certification period when the recipient has not provided required information. Allow for timely notice.

G. If you do not complete the Medicaid re-enrollment in time to send the appropriate notice and enter the information in EIS, authorize the case one month at a time until eligibility or ineligibility is established. (This does not apply to NCHC.)

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(II.)

H. Deductible Cases

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 re-enrollment 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:
 - 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.
 - (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-3215, Processing the Application.
3. Prior to termination, evaluate each individual in the case in other aid program/categories for ongoing benefits.

III. BEGINNING THE RE-ENROLLMENT PROCESS

A. Automated Re-enrollment for MIC and NC Health Choice

1. The re-enrollment process for MIC-N, MIC-1 and re-enrollment for NC Health Choice for Children (MIC-J, K, S, A) is automated.
 - a. The state mails a postcard (DMA-5067) to recipients 10 calendar days before the re-enrollment forms are mailed. The postcard tells the recipient a re-enrollment form is coming and to return the form to the county dss.

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(III.A.1.)

- b. At the beginning of the 11th month of the certification period, the State mails the recipient:
 - (1) A DMA-5063R,
 - (2) A cover letter (DMA-5063I),
 - (3) A return envelope (DMA-5063EE) imprinted with Health Check/NC Health Choice for Children logo, and
 - c. Recipients are instructed to complete the DMA-5063R and return it to the county dss to the address listed on the cover letter (DMA-5063I) by the 25th day of the 11th month of the certification period.
 - d. EIS terminates the case on pull night of the following month (the 12th month of the certification period) if eligibility is not updated in the system. Pull is the fourth work night from the end of the month.
2. The Case Management Report
 - a. MIC and NCHC cases due for review initially display on the Case Management Report two months before the certification end date.
 - b. This report is printed the last workday of each month.

Example: If a certification period ends December 31, the review due message is displayed on the Case Management Report that is run on October 31.
 - c. Two copies are mailed to each county to be received by the first week in the following month. The report is also available in NCXPTR. Refer to EIS Manual Section 1061 for accessing the Case Management Report on NCXPTR.

B. Beginning the MAF or MPW Mail-in Re-enrollment

1. MAF or MPW re-enrollment may be completed by mail, by face-to-face or telephone interview. Mail-in re-enrollment is recommended. (See III.C. below for instructions on the face-to-face or telephone interview.)
2. The re-enrollment process for MAF (C, N, or M) and MPW is not automated. The caseworker must initiate the process.
3. Case Management Report
 - a. MAF
 - (1) An MAF review due message is displayed on the Case Management Report three months prior to the last month of the certification period.

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(III.B.3.a.(1))

Example if a certification period ends December 31, the review due message is displayed on the Case Management Report that is run on September 30.

- (2) The appointment letter (DSS-8189) and mailing labels generated by EIS are mailed to each county.

b. MPW

If the “B” special review code and the month the baby is due are entered correctly in EIS, the message “Baby Due” appears on the Case Management Report in the month the baby is due. This indicates that a re-enrollment for the pregnant woman must be completed prior to the end of her pregnant woman coverage.

4. Identify MAF & MPW cases due for re-enrollment.
6. Prepare a re-enrollment packet. Include:
 - a. The DMA-5063 or the DMA-5063R and the DMA-5063I, and
 - b. The DMA-5065 - Reserve supplement for MAF applications, and
 - c. The DMA-5046 – Medical Assistance Transportation Notice of Rights,
 - d. A pre-addressed return envelope. Write or stamp “MAF Re-enrollment” and the IMC's name on the envelope.
 - e. The DMA-5021, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Health Check fact sheet.
7. Mail the re-enrollment packet the first week in the month before the last month of the current certification period. Set up an internal control to flag the record on the “return by” date written on the cover letter (DMA-5063I).
 - a. Do not include the timely notice with the re-enrollment packet.
 - b. Do not propose termination until the family has failed to return the form.

C. Scheduling the MAF/MPW Face-to-Face or the Telephone Interview

A face-to-face or telephone interview may be completed if the recipient needs assistance to complete the re-enrollment process. The face-to-face interview may be an individual interview at the county dss, a group interview at the county dss, or an announced home visit. Home visits are at the discretion of the county.

1. Begin the re-enrollment in time to meet timely notice requirements prior to expiration of the certification period.

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(III.C.)

2. Refer to the Case Management Report to determine when a review is due. Identify cases that are due for review.
3. Appointments:
 - a. Face to Face Interviews
 - (1) Send the appointment letter (DSS-8189) that is generated by EIS three months prior to the end of the certification period. Retain a copy of the letter in the case record. For MPW re-enrollments the county must create a similar appointment letter.

Option: The IMC may mail the re-enrollment forms along with the appointment letter so that the recipient can complete the forms prior to the interview.
 - (2) Do not include a timely notice with the appointment letter.
 - b. Telephone Interviews
 - (1) Contact the recipient to schedule the telephone interview. Explain to the recipient the telephone interview process. Document the appointment date and time in the case file.
 - (2) Contact the recipient on the date and time of the interview.
 - (3) If the recipient does not keep the appointment, send a timely notice of proposed termination requesting he contact you to conduct the telephone interview.
 - (4) After the interview is completed, send the recipient the re-enrollment forms to sign. **Send the PMH handout if appropriate.** Allow 12 calendar days for the return of the forms. If the forms are not returned by the deadline, send a timely notice to terminate.

IV. TRACKING MAIL-IN RE-ENROLLMENT FORMS

A. Getting Packets to Appropriate IMC

Train mailroom staff to recognize returned re-enrollment forms so the forms can be date-stamped and forwarded to the appropriate unit for processing. Do not register the re-enrollment form on the mail-in log as an application unless coverage is requested for a person who is not a recipient.

B. Automated Re-enrollments and MAF/MPW Mail-ins Not Returned by the Deadline

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(IV.B.)

1. Automated Re-enrollments

If the automated re-enrollment form is not received by the 25th day of the 11th month, send a manual timely notice.

a. On the timely notice, inform the recipient that eligibility will be terminated for not completing the re-enrollment process if the form is not returned by the end of the timely notice period.

b. Keep a copy of the manual timely notice in the case record.

2. MAF/MPW Mail-in

If the MAF/MPW Mail-in, including the DMA-5065, Reserve Supplement, is not returned by the deadline, send a timely notice to terminate at the end of the certification period for failure to complete the re-enrollment process.

3. For Both Automated Re-enrollment and MAF/MPW Mail-in

a. If the form is returned incomplete or unsigned, return the form to the client with a manual timely notice. For automated re-enrollments, always send manual notices.

b. If information requested on the form is not submitted with the form, refer to V.B.2. below for steps to follow.

c. If additional information is needed to determine eligibility, send the recipient a request for information. Allow 12 calendar days for the return of the information. If the information is not returned, send a timely notice to terminate.

C. Forms Not Received by the Recipient

Follow these procedures when the mail-in re-enrollment form is not received by the deadline and the recipient responds to the timely notice that he did not receive the review packet.

1. If the recipient reports that the re-enrollment form was not received or has been misplaced, the county must set procedures to assure that the re-enrollment is completed. Suggested procedures:

a. Automated Re-enrollments

Mail the recipient a copy of form DMA-5063 (Do not include the rights and responsibilities.) and the forms in the MAF re-enrollment packet, except the DMA-5065. Include a new return date.

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(IV.C.1.)

- b. MAF/MPW Re-enrollment

Send the recipient another re-enrollment packet. Include a new "return by" date and flag the case for the new date.
 - c. When mailing the re-enrollment form, enclose a self-addressed envelope so that the form is returned to the appropriate IMC and is not listed on the mail-in log for applications. Write "Re-enrollment" and the IMC's name on the envelope and the form.
 - d. Include a timely notice with the re-enrollment form proposing termination if the re-enrollment form is not returned by the end of the 10 workday period.
 - e. Note in the case record that a second form was mailed to the recipient to complete the re-enrollment process.
 - f. If the recipient wishes to come into the county dss for an interview, use the DMA-5063 as the re-enrollment form.
2. Re-enrollment packets with DMA-5063 or DMA-5063R returned as undeliverable.
 - a. If the re-enrollment packet is returned to the agency as undeliverable, make all reasonable attempts to locate a current address. Refer to MA-3410, Terminations/Deletions, for definition of a current address.
 - b. If an address is located in NC, mail the packet to the correct address with a new "return by" date and flag the case for the new date.
 - c. If an address is not found, document the case record listing all attempts to locate an address. Terminate the case for unable to locate after sending timely notice.
 3. Terminate for failure to return the re-enrollment form
 - a. MIC-N/MAF/HSF/MPW

Terminate the case at the end of the certification period after timely notice has been given. If the notice period has not expired by pull date, authorize the case for an additional month.
 - b. NC Health Choice
 - (1) If the recipient has not previously been given timely notice, send a timely notice that the case is ineligible for ongoing benefits.
 - (2) Do not update the ongoing certification period.

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(IV.C.3.b.)

- (3) The case will terminate automatically on pull night of the 12th month of the certification period.
- (4) Do not authorize an additional month.

D. Recipient's Request

1. Recipient does not want automated or mail in re-enrollment

If the recipient prefers to complete the re-enrollment process with a face-to-face or telephone interview, schedule an appointment according to instructions in III.C.

2. Recipient requests Medicaid termination - Mail-in/Automated Re-enrollments
 - a. The request must be in writing and specifically request Medicaid termination. Send the recipient an adequate notice to terminate at the end of the certification period.
 - b. If the request is not in writing, send a timely notice.
 - c. Ensure that the recipient understood that he or the children may still be eligible for Medicaid and chose not to continue. Document the record.

V. EVALUATE RE-ENROLLMENT FORMS UPON RECEIPT

A. Definition of a Complete Form

To complete the re-enrollment process, the DMA-5063 or the DMA-5063R must be completed and received in the county dss. A "complete" form is one that contains the following:

1. A signature, and
2. Requests coverage for at least one child who is in the existing case being reviewed.

B. Steps to Take When Information is Missing From the Form

1. If the form is returned incomplete or unsigned, return the form to the client with a manual timely notice.
2. If information requested on the re-enrollment form is not submitted with the form:
 - a. Search agency records to determine if the agency has current information. Refer to MA-3300 Income, for a definition of what constitutes current verification.

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(V.B.2.)

- b. Document findings in the county case record.
- c. If the agency records do not contain the income verifications, send the recipient a timely notice to terminate the case.

VI. RECEIPT OF CORRECT MAIL-IN FORMS

A. Automated Re-enrollments

Mail the recipient the DMA-5046, Medical Transportation Assistance-Notice of Rights, once the re-enrollment form is received. Allow at least 12 calendar days for return. For re-enrollments conducted in the office, complete the DMA-5046 during the interview.

1. If the DMA-5046 is not returned by the deadline, process the re-enrollment following applicable eligibility requirements. The DMA-5046 is not an eligibility requirement.
 - a. Review the DMA-5046. If the client indicates he wishes to request assistance with transportation, assist the client in scheduling transportation for Medicaid covered services.
 - b. File the DMA-5046 in the record. No action is required in EIS.
2. If the DMA-5063 or DMA-5063R is returned and the caretaker responds “yes” to both questions in one of the boxes for questions 1 -5 on page 4, the child has special health care needs. Enter the appropriate code in EIS.
 - a. If the DMA-5063 or DMA-5063R is returned and both questions in one of the boxes for questions 1 – 5 on page 4 are checked “yes” and there is no name listed, call the client to get the name of the child. If you are unable to reach the client by phone, mail the DMA-5063 or DMA-5063R to him asking him to write the name of the child and to return the form as soon as possible.
 - b. Do not attempt to contact the client if only one question is answered “yes” on questions 1 – 5 on page 4 and the other is blank or if the parent did not sign the DMA-5063 or DMA-5063R.

B. Compare The Form to The Last Form in Record

Review the DMA-5063 or the DMA-5063R and compare information on the form to the last re-enrollment or application to determine if there are any changes that may need follow-up.

C. Request for Coverage For a Caretaker or an Additional Child

If the re-enrollment forms, DMA-5063 or DMA-5063R, request coverage for a caretaker or a child not included in the original case, treat as an application.

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(VI.C.)

1. Enter an unsigned DSS-8124 to register an application.
2. The date of application is the date the DMA-5063 or DMA-5063R is received in the agency and is complete. Always date stamp the date the application or other information necessary for processing the application is received in the agency. If an application is received for a case that is pending county reassignment, follow instructions in MA-3340, County Residence, to complete the re-enrollment. Process the application after the re-enrollment is complete.
3. Application processing requirements found in MA-3200 and MA- 3217 apply to the application. This includes an evaluation in all Medicaid aid program/categories, including MPW or MAABD.
4. If the information included on the application indicates that the individual(s) should apply for Aged, Blind and Disabled Medicaid program:
 - a. Within one workday of receipt of the application, send the DMA-5063 or DMA-5063R, Health Check/NC Health Choice for Children Application, to the appropriate Medicaid unit within the agency.
 - b. Document on the log that the application was sent to another unit.
 - c. The date of the Aged, Blind and Disabled Medicaid application is the date that the complete DMA-5063 or DMA-5063 was received in the agency.
 - d. Do not require the individual to sign another application.
 - e. Use the DMA-5063, DMA-5063R, or DMA-5000 to process the application for the adult or child or both in the most appropriate Medicaid category.
5. Enter the application on the DMA-5066, Log for NC Health Choice/Medicaid Mail-In Applications as specified in MA-3207, Receiving Mail-In Applications.

VII. CONDUCTING THE MAF/MPW FACE-TO-FACE OR THE TELEPHONE INTERVIEW**A. Failure to Come to Appointment**

If the recipient fails to keep the appointment, terminate the case at the end of the certification period after timely notice has been given. If notice has not expired, authorize the case for an additional month.

B. Procedures

1. At the interview, complete forms DMA-5063 and DMA-5065.

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(VII.B.)

2. Review the forms with the recipient. Compare the forms with the forms on file. If there are questions about the information provided, ask the recipient to clarify the information and/or provide documentation.
3. Signing Forms
 - a. Face-to face interview – While in the interview, ask the recipient to sign all forms that require his signature.
 - b. Telephone interviews - Mail the recipient forms he must sign to complete the re-enrollment process.
4. Inform the recipient/representative that he will be notified of any changes to be made in his medical assistance following the re-enrollment.
5. Instruct homeless recipients with no permanent address to come to the agency on the first day of the month to pick up their ID card and necessary notices. Attach notice of the re-enrollment to their ID card. If the recipient fails to pick up his ID card for two consecutive months, propose termination for inability to locate.
6. Review items C. through F. below with the recipient.

C. Responsibility to Cooperate With The County DSS

Inform the recipient/representative that he is responsible for cooperating with the county dss in providing information necessary for determining continuing eligibility. Explain 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 information on bills incurred for medical expenses when he has a deductible and 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."

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D. Inform The Recipient of His Rights

Inform the recipient of his rights and responsibilities. Emphasize the following points:

1. Information given to the agency is confidential
2. He has the right to request termination from the Medicaid program at any time.
3. He may continue to be certified for Medicaid if found eligible, based on the rules in MA-3425, Certification and Authorization. Explain the concept of deductible or patient monthly liability, if applicable.
4. He has the right to reapply at any time if found ineligible or his case is terminated.
5. He has the right, following a local appeal, to appeal within the appropriate time limit to the Division of Social Services (Refer to MA-3430, Notice and Hearings Process.) if:
 - a. Medicaid is terminated,
 - b. He disagrees with having a deductible or the patient monthly liability,
 - c. He believes the amount of his deductible or patient monthly liability is incorrect,
 - d. He believes the county dss is delaying action in investigating his request for a review of his circumstances.
6. Explain the protection against discrimination on the grounds of race, creed or national origin by Title VI of the Civil Rights Act of 1964.

E. Explain Transfer of Resources

Inform the recipient that if he transfers any real property, personal property or liquid resources out of his name without receiving compensation equal to the current market value for the transferred resource, the transfer may result in a period of ineligibility. If the a/r needs assistance, now or in the future, with nursing home cost of care under the MAF program, CAP, or assistance with in-home health services and supplies under the MAABDQ programs, a sanction may be imposed. Refer to MA-2240, Transfer of Resources, in the Aged, Blind, and Disabled Medicaid Manual.

Document the recipient responses regarding transfer of resources in the case file.

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F. Inform the Recipient of Other Services

1. Family Planning Services

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 MA-3205, Conducting a Face-to-Face Intake Interview, for details.

2. Health Check Program

Remind each recipient of the benefits of the Health Check Program. See MA-3205, Conducting a Face-to-Face Intake Interview, for details.

3. Explain the Food and Nutrition Services

Inform the recipient of the Food and Nutrition Services (FNS) 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 (FNS) staff, e.g., deductible information, copy of the DMA-5036, Record of Medical Expenses Applied to the Deductible, etc.

4. Explain The Women, Infants, and Children (WIC) Program

- a. Explain the availability of benefits through WIC.

This program provides a nutritional supplement to 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. Make a 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."

5. Explain Lifeline/Link-Up Assistance Program

Lifeline provides a monthly discount on an eligible recipient's local telephone bill. If the recipient does not have a telephone, Link-Up provides a 50% discount, up to \$30, on the cost of connecting local telephone service.

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(VII.F.5.)

To be eligible for Life Line/Link Up the individual must: Receive Medicaid under MAF, MPW, MAABD, MQB-Q, MQB-B or MQB-E and receive telephone service listed in his name from one of the telephone companies listed on the DMA-5058, Participating Telephone Service Providers.

The caseworker must provide applicants/recipients information on Lifeline/Link-Up and provide households with the address of their participating telephone service provider (see DMA-5058). Instruct households to complete the DSS-8168-I and mail it to their telephone service provider if they meet the eligibility requirements for Lifeline/Link-Up. Refer to MA-3205, VI. F, Conducting A Face-To-Face Interview for Life Line/Link Up.

6. Other Available Services

- a. Explain that other services are available within the department and make a referral for any services requested.
- b. Explain the use of the Medicaid Identification (MID) 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-3505, 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.
- c. Provide recipients with the appropriate Medicaid handbook if a request is made. The handbooks are provided to families at the time of application and there is no requirement to provide them again at re-enrollment.
- d. Explain the benefits of choosing a Pregnancy Medical Home (PMH) and, give a copy of the PMH handout. Refer to MA-3205, VI. B., Conducting A Face-To-Face Interview for PMH.

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(VII.F.)

7. Inquiries of Issuance of Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires that group plans and health insurance issuers which offer group coverage furnish certificates of creditable coverage when an individual ceases to be covered by the plan. The certificate issuance is automated and issued by the fiscal agent when a recipient is terminated. Certificates can be provided up to 24 months after termination. If a recipient inquires about a Certificate of Creditable coverage, refer him to the fiscal agent.

8. National Voter Registration Act (NVRA)

The purpose of the NVRA is to make available more opportunities for people to vote. Voter registration forms are to be available to recipients during their visits for their re-enrollments.

- a. If a recipient asks for assistance in completing voter registration forms, assist the recipient.
- b. Inform recipients that the Board of Elections processes applications to register to vote and questions concerning voter registration must be directed to the local Board of Elections.

VIII. DETERMINING ELIGIBILITY

A. Processing Requirements

1. Determine eligibility based on the requirements for the aid program/category you are evaluating.
2. Review the form and compare information to the last re-enrollment or application to determine if there are any changes that may need follow-up.
3. Verify eligibility factors that are subject to change, such as income, household composition or resources.
 - a. Request only information from the recipient when it is necessary to determine ongoing eligibility.
 - b. If information is current or is already available to the agency, do not request it from the recipient. Refer to MA-3300, Income, for what constitutes current and available.
4. If verification of income, countable resources or other information is questionable, contact the casehead by telephone or in writing.

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(VIII.A.4.)

- a. If the request is in writing, use the DMA-5097, or DMA-5097S
- b. If a telephone request is made, advise the recipient what information is needed and that he may request assistance in obtaining the necessary information. Document the record to show the date of the telephone contact, the specific information requested and that the recipient was offered assistance.
- c. Set a deadline for the recipient to return the information that is 12 calendar days from the date of the request. Explain to the recipient that he is responsible for providing necessary information by the deadline.

B. Requested Information is Not Received

1. Make every attempt to process the re-enrollment no later than “pull” in the last month of the certification period.
2. If verification is not received by the deadline, send a timely notice proposing termination for failure to provide necessary information. Terminate the case at the end of the certification period provided timely notice has been given and timely notice period has expired by pull date in the last month of the current certification period.
 - a. MAF, MPW, & MIC-N cases

If notice has not expired, authorize the case for an additional month. Follow instructions in EIS-3051 to issue benefits.
 - b. NC Health Choice

Do not authorize an additional month.

C. Evaluate for Medicaid In All Categories or NC Health Choice Prior to Termination

1. If the recipient no longer meets the eligibility criteria under the original aid/program category, evaluate eligibility in all other aid program/categories.
 - a. Transitional Medicaid (MAF-C). Refer to MA- 3405, Twelve Month Transitional Medicaid.

If a pregnant woman would have been eligible for MAF-C when she became employed or otherwise had an increase in earned income that results in her now being ineligible for Medicaid, evaluate for Twelve Months Transitional Medicaid.
 - b. Four Month Transitional (AAF payment type 4). Refer to MA-3400, Four Months Transitional Medicaid.

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(VIII. C.1.)

- c. If the recipient is moving from MIC to NCHC, do not key an 8124 until the fee is paid or the insurance is terminated. Refer to MA-3255, NC Health Choice.
2. Other possible programs
 - a. MAA if the record verifies an assistance unit member is 65 years or older, or
 - b. MAD if the record verifies an assistance unit member receives Social Security disability or there is a DMA-4037 in the record verifying that the assistance unit member has been determined disabled. If the DMA-4037 is in the case record but there is a subsequent denial of disability, evaluate the caretaker for all other aid program categories.
 - c. MPW when the question, Is anyone in the home pregnant, is checked yes. If the pregnancy verification was not submitted, contact the recipient to request verification of pregnancy to evaluate for MPW. Allow 12 calendar days to provide the verification of pregnancy. If the a/r requests more time to get the verification, allow an additional 12 calendar days.
 - d. MAF for women who qualify for Breast and Cervical Cancer Medicaid (BCCM). Refer to MA-3250, Breast and Cervical Cancer Medicaid.
 - e. MAF-M when the income exceeds the categorically needy income limits. Refer to II.F. for policy on certifying a case in deductible status.

IX. DISPOSITIONS

A. Enrollment Fees

If an enrollment fee is due for NC Health Choice because income is greater than 150% of the poverty level, do not re-enroll the case unless the fee is paid.

1. Once eligibility has been determined and it has been determined that the family must pay an enrollment fee, send a written notice instructing the recipient to pay the fee within 12 calendar days of the date of the notice.
2. If the fee is paid, re-enroll for ongoing NC Health Choice eligibility.
3. If the fee is not paid within 12 calendar days, do not update the certification period. Send a timely notice proposing termination.
4. If the recipient is moving from MIC to NCHC, do not approve for NCHC until the fee is paid.

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(IX.A.)

5. If the fee is paid and the case terminated because the 12th calendar day falls after "pull night" refer to reopen procedures in XIII. below. If NCHC is frozen, then follow policy in MA-3255, NC Health Choice.
6. If a MIC child is being added to a NCHC case at the NCHC review, do not charge an enrollment fee for the child being added. Do not charge a \$100.00 fee until the next NCHC review after the child has been on the case for a year. See MA-3255, NC Health Choice, for policy on changes in household composition.

B. All Eligible/Some Eligible

1. Re-enrollment of all children in the same aid program/category (MIC-N remains MIC-N and/or NCHC (MIC J, K, S, A) remains NCHC):

Follow instructions in the EIS Manual to update eligibility on the DSS-8125 screen for MIC (N) or NC Health Choice (MIC - J, K, S, A). The certification period is 12 months.
2. Children are eligible for MIC (N) who were previously authorized for NC Health Choice (MIC - J, K, S, A).

Follow instructions in the EIS Manual to update eligibility on the DSS-8125 screen. The certification period is 12 months.
3. Approving NC Health Choice (MIC - J, K, S, A) for children previously MIC (N):
 - a. Complete a reapplication to change the MIC classification and approve NC Health Choice.
 - b. If NCHC is frozen, follow policy regarding the freeze in MA-3255, NC Health Choice.
4. Some children are eligible for MIC/MAF and others for NC Health Choice:
 - a. Delete the Medicaid eligible children from the case. Enter an administrative application to open a new MIC case.
 - b. The children eligible for NC Health Choice remain in the original case.
5. Some children are eligible for NC Health Choice Code L and others Codes J, K, S, A:
 - a. Delete the children eligible for NC Health Choice Codes J, K, S, and A.

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(IX.B.5.)

- b. Enter an administrative application to open a new case for the children with Codes J, K, S, and A.
 - c. The children eligible for NC Health Choice Code L remain in the original case. Ensure the appropriate code is entered into EIS to transfer the NCHC case to an L classification.
6. Process the re-enrollment and update the certification period in EIS by "pull night" of the 12th month of the certification period.
 7. If eligibility is established for everyone in the assistance unit, authorize assistance in EIS no later than "pull" in the last month of the certification period. The length of the new certification period is based on the category.

Example There is a 12 month certification period for MIC or Health Choice, and 6 month certification period for MAF-M or MAD. For MPW, the certification period goes through the post partum period.

8. If any one in the assistance unit is ineligible for ongoing Medicaid in any category including MPW, MAABD or NC Health Choice, send a timely notice to terminate Medicaid.

C. Process by Pull or Extend

Process the re-enrollment to authorize ongoing Medicaid or send timely notice to terminate no later than "pull" in the last month of the certification period. If the review is not completed by this time, authorize the case for an additional month in order to complete the re-enrollment and allow for timely notice requirements.

1. Do not authorize cases for an additional month:
 - a. If the case is NCHC, or
 - b. The case is in deductible status at the end of the certification period.
2. If the re-enrollment is completed after extending the certification period for a month and the case remains eligible, use the one month certification period as the first month of the new certification period.

D. Termination or Beginning Deductible

If the result of the re-enrollment is ineligibility or changing from authorized to deductible status, send a timely notice. The timely notice should end prior to the "pull" in the last month of the certification period.

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(IX.D.)

1. MIC-N/MAF/HSF

Terminate the case or certify in deductible status if timely notice has expired by “pull” in the last month of the current certification period. If notice period has not expired, authorize the case for an additional month.

2. NC Health Choice

- a. If the recipient has not previously been given timely notice, send a timely notice that the case is ineligible for ongoing benefits. If it will be certified for Medicaid with a deductible, include this information on the notice.
- b. The case will terminate automatically on pull night of the 12th month of the certification period, if the certification period has not changed.

X. NEWBORN PROTECTION

When re-enrolling a formerly pregnant woman at the end of her post partum period, evaluate her child(ren) for automatic newborn protection. Refer to [MA-3230](#), Eligibility of Individuals Under 21.

XI. CHILD SUPPORT

For MAF/MIC (N)/MIC 1, follow procedures in [MA-3365](#), Child Support.

For NCHC (MIC J, K, S, A), follow procedures in [MA-3255](#), NC Health Choice.

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

CCNC/CA are managed health care programs for Medicaid 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-3435](#) for CCNC/CA policy.

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(XII.)

A. Face-to-Face and Telephone Re-enrollments

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-9017, CCNC/CA: The Benefits of Being a Member-NCHC, 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-3435, 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.
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-3435, 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.

B. MIC and MAF Mail-in Re-enrollments

1. During the 11th month, the state mails the recipient DMA-5063R, Health Check/Health Choice Re-enrollment to MIC cases. The re-enrollment asks the recipient if he is receiving CCNC/CA or if he would like to change his provider. If the recipient does not request to change the doctor, leave the CCNC/CA information as is.
2. Explain CCNC/CA and provide a list of appropriate CCNC/CA care providers.
3. Assist the recipient in choosing a PCP at this time.

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(XII.B.)

4. If the recipient chooses a PCP (or is otherwise exempt), complete the **Carolina ACCESS Enrollment Form for Recipients of Medicaid and Health Choice (DMA- 9006.)** Enter the CCNC/CA provider or exemption number in EIS and file the form in the record.
5. If the recipient cannot choose at that time or if there was no contact with the recipient, mail the recipient a list of CCNC/CA primary care providers. Do not include the PCP's provider number on this list. Ask the recipient to contact you with a choice. Flag the case for a response.
6. If the recipient does not make a choice by the time the case is processed, assign an appropriate PCP for each individual and complete the CCNC/CA Enrollment Form. Enter the provider number in EIS.
7. Mail the CCNC/CA Recipient Handbook including the PCP name and phone number to the recipient.

C. Questions Regarding CCNC/CA

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

XIII. REOPENS**A. A case which terminates for not cooperating with the re-enrollment process (i.e, failure to return the review document or failure to provide information) may be reopened if certain criteria are met:**

1. The case meets criteria in MA-3215, Processing the Application.
2. The re-enrollment form and all information necessary to approve eligibility is received by the 10th of the month following termination.
 - a. If the NC Health Choice client received notification of the enrollment fee, it must be paid by the 10th of the month.
 - b. If an enrollment fee is due, it must be paid by the 10th of the month following termination. If it has not been paid, do not reopen the case. If the client is not notified that a fee is due until the 10th day, give the client 12 calendar days to pay the fee.
3. Reopen the case in EIS as an administrative application. Enter "Y" in the ADMIN field on the DSS-8124 screen. The date of application is the first day of the month following termination.

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(XIII.)

B. If the completed re-enrollment form (DMA-5063R) is received after the 10th of the month, do not reopen the case.

1. Treat the signed re-enrollment form as an application. Do not require the recipient to complete and sign a DMA-5063.
2. Enter a reapplication in EIS. All application processing standards apply. The application counts in the report card.
3. The date of application is the date the re-enrollment form is received and is complete.
4. If income can't be verified through other current agency records, request verification of income.
5. Verify other eligibility factors as necessary. Use current agency records.
6. If an enrollment fee is due for NC Health Choice, allow the recipient 12 calendar days to pay the fee before denying the application. Refer to MA-3255, NC Health Choice.

C. If the re-enrollment form was previously received, but information needed to process the re-enrollment (including the enrollment fee) is not received until after the 10th of the month, do not use the re-enrollment form as an application. Require the recipient to complete a DMA-5063 to start the application process over.

1. Call or write the recipient and explain that he or she must reapply for benefits.
2. Send the recipient a DMA-5063 and return the enrollment fee if applicable.
3. When the completed DMA-5063 is received, follow application processing procedures in MA-3255, NC Health Choice, or MA-3215, Processing the Application.