

Department of Public Health
and Human Services

Section:
CASE MANAGEMENT

FAMILY RELATED MEDICAID

Subject:
Reporting Changes

Supersedes: FMA 1501-1 (01/01/03)

Reference: 42 CFR 431.213; 435.916 and .919; ARM 37.82.101

▶ **GENERAL RULE**--All Medicaid applicants and recipients are required to report changes in their household circumstances as soon as possible but within ten (10) days of **knowledge** of the change to allow the appropriate action to be taken prior to benefit issuance. Form HCS-260A, "Change Report Form" will be provided at the initial eligibility determination, following a reported change, at redetermination, and upon request. If the individual did not request an interview, the HCS-260A must be mailed to them.

▶ **NOTE:** Staff will send notice M012 'Change Report Requirements' after initial eligibility determination, at redetermination and any time a change was not reported timely.

▶ Applicants and recipients may report changes at any time and are encouraged to report all changes even if they believe the changes are insignificant. Their eligibility case manager will evaluate the changes and apply the information appropriately as eligibility is redetermined.

▶ If changes are not reported or are not reported timely, correct benefits may be delayed or the assistance unit may be required to repay benefits issued incorrectly (see FMA 1504-1 'Overissuance').

All reported/discovered changes must be treated as if made timely (within ten days of knowledge of the change) and also allow time (ten days) for notice of adverse action to establish which benefit months were possibly overpaid.

EXAMPLE: An income increase known March 15, but not reported until April 30, may result in the May Medicaid benefits being issued when the individual/family isn't eligible.

ACTION: A Medicaid overissuance is calculated for May. The 10-day reporting time period ends March 25. There aren't ten days remaining in the administrative month (March) in which to provide timely notice to the recipient reducing April's benefits. Therefore, Medicaid is authorized for April. No overissuance is calculated for April.

► **WHO IS REQUIRED TO REPORT?** All filing/assistance units, eligible for, applying for and/or receiving Medicaid benefits are required to report changes in their circumstances and provide verification of the change(s).

► **NOTE:** Not all changes are required to be verified. If the reported change will obviously close the current FMA coverage, no verification is required, unless an ex parte review indicates they may be eligible for other Medicaid coverage. If the family/individual appears eligible for another FMA program, it may be necessary to request verification prior to opening the other program. Adequate and timely notice rules apply (FMA 1503-1). Income and resources must always be verified at application, redetermination and whenever a change is reported.

WHAT IS TO BE REPORTED? The following circumstances must be reported as soon as possible but within ten (10) days of knowledge of the change to assure benefits are issued promptly and correctly:

NOTE: Changes may be reported throughout the entire administrative month.

- 1. Changes in income source or in the amount of gross monthly income, including, but not limited to:
- a. Changes in hours worked or pay per hour/pay period;
 - b. Promotion or demotion;
 - c. An additional job;
 - d. A different job;
 - e. Lump sum payments such as lottery winnings, settlements;
 - f. Vendor payments for child care assistance;
 - g. Disability/death benefits;
 - h. Child support payments (received or paid out).
- 2. A household member with/without income that must be added/removed (FMA 202-1/202-2);
3. Changes in residence and the resulting changes in living arrangements.
4. Buying or selling a vehicle; and
5. When cash on hand, stocks, bonds, and money in a checking or savings account increases or decreases.

- ▶ 6. Changes affecting coverage level, such as:
 - a. Pregnancy begins or ends;
 - b. Moving into of out of a nursing home;
 - c. Being determined disabled
- ▶ The date these changes are reported is considered the 'coverage request date' for the higher coverage level (full coverage for pregnancy or disability, nursing home coverage, etc.). Any retro months requested are based on the coverage request date.
- ▶ For example, if a family is opened on Family Medicaid coverage beginning January 1, 2005, and on June 12, 2006 the mother reports she is pregnant and due in July, her coverage request date for full coverage is June 12, 2006. Retro full coverage can be evaluated, and, if all eligibility requirements are met, authorized for only March, April and May, if requested.

▶ METHODS OF REPORTING CHANGES

Applicants and recipients can report changes by:

1. Completing and returning the "Change Report Form" (HCS-260A),

▶ **NOTE:** Applicants and recipients **cannot** be required to report changes on Form HCS-260A.

2. Telephoning or writing the county OPA,
3. Writing or telephoning the eligibility case manager directly, or
4. Reporting the change in person.

NOTE: County office staff may also discover information from sources such as newspapers, anonymous calls/letters, WoRC Case Manager, R & R Agencies, SEARCHS, MISTICS, DMV (Dept. of Justice – vehicles), State Fund (Workers' Comp), etc. When information is discovered, the recipient must be given the opportunity to respond before action is taken. The eligibility case manager will send a system notice notifying the applicant or recipient of the discovered information and requesting verification to substantiate or dispute it.

The eligibility case manager will evaluate the effect the change may have on all eligibility requirements, nonfinancial as well as financial. For example, if the individual reports an increase in income due to an increase

in work hours, this change may also affect the dependent care expense amount.

ACTING ON REPORTED CHANGES

The eligibility case manager must take an action on all changes reported to, or discovered by the agency, within ten days of the reported/discovered change, regardless of the timeliness of the report.

“To take an action on changes reported/discovered” can mean any or all of the following actions:

1. Redetermining eligibility,
2. Requesting verification and/or more information,
3. Recalculating benefit/incurment amount,
4. Taking adverse action (reduction or termination of benefits),
5. Establishing an overissuance, OR
6. Simply documenting in system case notes that a change was reported/discovered, evaluated, and no further action was required.

Action must be taken promptly and must occur even if system-processing time frames prevent a correction to benefits prior to actual issuance.

NOTE: Cutoff occurs at 3:00 p.m. on the fourth working day from the last calendar day of the month. Any action taken on an authorized case after cutoff will not reflect on eligibility for the next benefit month.

► VERIFICATION OF THE CHANGE

When an applicant or recipient reports a change that affects eligibility or incurment amount, verification (a document or statement from a collateral contact) of that change must be obtained as soon as possible. Specific time periods are stated later in this section according to the outcome of the redetermination of eligibility and/or benefit. If verification is not submitted with the reported change or information is discovered, the applicant or recipient is informed (via a system notice) that they must provide the necessary verification within 10 days of the notice date. **Staff must always follow up verbal requests with a system notice.**

► **NOTE:** If the reported change will close the current FMA coverage, and an ex parte review does not indicate that they may be eligible for other coverage, it does not need to be verified.

► For example, Velma reports on October 12th that she got a \$.50 per hour raise. Both she and her daughter are receiving Medicaid through the Family program. The change needs to be verified, because if Family closes based on

income, her daughter may be eligible for Child-Under Age 6 coverage, or they may both be eligible for Family-Transitional.

The reported change and actions taken are documented in system case notes.

NOTE: **The request for information notice cannot be used as a notice of adverse action.** If the applicant/recipient does not respond to the notice and eligibility cannot be determined without that information, a timely notice of the adverse action must be sent (FMA 1503-1).

► ADDING A HOUSEHOLD MEMBER

If the presence of a new household member is reported to or discovered by the agency, redetermine the assistance unit(s)'s eligibility by including the new household member(s)' presence, income and resources as required by policy.

If a new household member is a spouse or parent who would be financially responsible, deemed or otherwise considered in the eligibility determination for current household members (whether or not he/she is requesting Medicaid benefits), HC-261A "Adding a New TANF or Medicaid Household Member" form is required to be completed and signed by the new member or authorized representative (if an adult) or an adult household member (if not an adult).

The new member may receive up to three months of retroactive Medicaid coverage from the month of discovery/report that he or she entered the household or date of request for retroactive Medicaid coverage (whichever is later), provided **ALL** eligibility factors are met for that person in each of the retroactive months. Eligibility factors are determined based on the household in which that person lived during each of those retroactive months.

Redetermination of the eligibility of all household members must be conducted based on the presence of the new household member being reported, regardless of whether the new household member is requesting Medicaid for him/herself. The presence of another individual in a household could affect many issues, such as the filing unit, deeming, as well as income and resource eligibility for those currently receiving Medicaid.

If the member's presence, income and/or resources affect or may affect the eligibility or benefit determination of existing household members, verification of pertinent eligibility factors such as relationship, income and

resources must be provided by the household in order to determine the continuing eligibility for all household members.

USING SYSTEM CASE NOTES

Always use system case notes to explain the reported/discovered change and the action taken as a result of the report (even when no action is necessary).

Documentation should include:

1. A description of the change,
2. Date the change occurred,
3. Date the change was reported/discovered,
4. What verification was provided and/or requested,
5. How the change was reported/discovered (by phone, HCS-260A, written note, in person or a third party), and
6. Any other pertinent information.

EXAMPLE: On April 3, John submits paystubs for wages received in March. The wages do not vary from what is currently being used. No change in eligibility is necessary.

ACTION: The eligibility case manager should complete a system case note similar to: "John reported wages on April 3 and included paystubs for March 8th and 22nd. This information did not reflect a change to the current prospected monthly income. No change in eligibility necessary."

NOTICES ON ACTION TAKEN

When a change that will result in an adverse action is reported on a signed Change Report and enough information to determine ongoing eligibility is provided, the eligibility case manager will use **adequate** notice to inform the recipient of the action (FMA 1503-1). Adequate notice is sufficient because the signed Change Report Form notifies the recipient of possible consequences.



NOTE: An applicant is entitled to written notice of the outcome of the eligibility determination; however, timely notice requirements do not apply to applicants.

When a change which results in an adverse action is reported by any other method, or there is not enough information on the signed HCS-260A to accurately determine ongoing eligibility (a notice must be sent requesting verification/information), the eligibility case manager must use a **timely** notice to inform the recipient of the action taken (FMA 1503-1).

► **CHANGES --
VERIFICATION
REQUIREMENTS**

WITHOUT VERIFICATION: When a reported/discovered change will result in benefit changes (increase or decrease), **but does not include necessary verification**, request verification to be provided within ten days of the system notice. If the verification is not received prior to cutoff or the ten-day period extends into the next benefit month, benefits are authorized at the benefit amount previously issued. **Do not increase benefits prior to receipt of verification** (i.e., decrease incurment, open parent, etc.).

- When the reported change will cause the current FMA coverage to close, there is no need to verify the change unless an ex parte review indicates that the family may be eligible for another FMA program.

If the eligibility case manager is unsure whether or not the reported change will close the current FMA coverage (i.e., reported income is very close to program limit), verification should be requested to ensure the proper actions are taken on the case.

Within ten days of receipt of verification, redetermine eligibility. Send appropriate system notice of the action taken. Document system case notes.

- If requested verification is not received within the stated time period or the administrative month and correct eligibility cannot be determined without it, benefits are terminated with timely notice provided, as ongoing eligibility cannot be accurately determined. If the verification is received after the stated time period but within the administrative month, benefits are redetermined, reopened if appropriate, and issued according to the information provided. Document in system case notes.

WITH VERIFICATION: When a reported change includes verification, the eligibility redetermination must be completed within ten days. If the action cannot be made prior to cutoff, release the benefit amount previously issued and correct eligibility no later than the 10th of the benefit month. Send appropriate system notice. Document system case notes.

- **EXAMPLE #1:** Susan, whose daughter receives Child-Under Age 6 coverage, reports on April 5, that she lost her job and her last paycheck will be received on April 10. She also reports she will receive \$52 per week from unemployment benefits. After a brief evaluation of the circumstances, the eligibility case manager determines this change will result in potential Family Medicaid eligibility for Susan and her daughter.



ACTION:

1. Budget the monthly unemployment benefits.
2. Evaluate for a possible change in childcare expense and employment hours.
3. Request verification of job end, last paycheck and unemployment benefits. Use 'client statement' in the verification field and set an alert for the due date. Also request any additional information needed to process Family for Susan (i.e., her birth certificate, CSED papers) if she wants this coverage.
4. Upon receipt of verification, redetermine eligibility:
 - a. Remove wage data from the system.
 - b. Remove/change the child care expense;
 - c. Set an ALERT for the next administrative month to access MISTICS for unemployment information.
 - d. Send appropriate system notice.
 - e. Document action taken in system case notes.



EXAMPLE #2: Mary, whose children receive Child-Age 6 to 19 coverage, reports on April 10, using Form HCS-260A, that her husband broke his leg April 2, and will not be able to work for three months. The family does not expect any income for the rest of April or the next few months, as he is not eligible for unemployment. After a brief review of the case, the eligibility case manager determines the change may result in potential Family Medicaid eligibility for Susan and her husband.

ACTION:

1. Send a system notice, requesting verification of employment status, the temporary disability, any change to child care expenses, and provide information about possible Family Medicaid coverage; set an alert for the verification due date.
2. **Upon receipt of the verification**, redetermine eligibility and benefits based on zero income.
3. Family Medicaid coverage should be processed immediately (if they want this coverage).
4. Send adequate notice of action taken. Document system case notes.

EXAMPLE #3: Dwight, a Family Medicaid recipient, calls on April 22 to report he found a job. He will be working full-time (40 hours/week) and earning \$13.00 per hour. The eligibility case manager briefly reviews the case and determines the change will result in Family Medicaid becoming medically needy.

ACTION:

1. Ask Dwight how often he will be paid, the pay dates, and if the job is expected to continue.
2. Request verification of employment, pay, etc. Enter 'client statement' in the verification field and set an alert for the due date.
3. Redetermine eligibility. It is determined that prospectively the case fails the GMI for household size.
4. Close the Family Medicaid case effective May 31, and open Family-Transitional effective June 1 (if Dwight's family has received Family Medicaid for at least 3 of the last 6 months). Send adequate notice.
5. Enter system case notes.

EXAMPLE #4: Jessie, a Family Medicaid recipient, submits a signed change report form on April 10. She reports she was awarded child support payments of \$950 per month beginning May 1. The eligibility case manager briefly reviews the case and determines the change will result in Family Medicaid becoming medically needy.

ACTION:

1. Request income verification. Enter 'client statement' in the unearned income verification field and set an alert for the due date.
2. Once verification is received, redetermine eligibility prospecting the child support income. If eligible, authorize benefits; if not, close the Family Medicaid case and open Family-Extended (if eligible).



NOTE: If Jessie is not eligible for Family-Extended (she didn't receive Family for 3 of the previous 6 months), it would not be necessary to verify the change, unless her children were potentially eligible for other coverage.

3. Send adequate notice explaining the action taken.
4. Document action taken in system case notes.

EXAMPLE #5: Gladys, a Child-Medically Needy recipient, called on April 5 to say she started working March 3 and received her first pay on March 15.

ACTION:

1. Request verification of new job. Enter 'client statement' in the verification field and set a system alert for the due date.
2. Redetermine eligibility for the May benefit month.
3. Send timely notice of adverse action if earned income causes the incurment to increase.
4. Upon receipt of verification, establish an overpayment for April. Send appropriate notice.

NOTE: Even though the report is not timely, the report must be treated as if it were to establish which benefit months were overpaid by allowing for the expiration of the ten days from the date the change was known and also allowing for the ten day timely notice of the adverse action. In the above example, if the report had been timely, it would have been submitted no later than March 13. The timely notice of adverse action period would have expired no earlier than March 23. This is before cutoff (3:00 p.m. March 26), which would have allowed time for the case to be reevaluated and benefits reauthorized at a different level for April.

EXAMPLE #6: Doris reports on April 27, using a signed HCS-260A, she started working on April 18.

ACTION: Request verification; redetermine eligibility for June. Document action taken in system case notes. **No overpayment for May is calculated.**

NOTE: The household reported timely. The report is received after cutoff giving the eligibility case manager no opportunity to recalculate and reauthorize May benefits. This is "no fault" of the recipient and "no fault" of the eligibility case manager.

PROCEDURE

ACTION

► Eligibility Case Manager:

1. Explain reporting requirements (send notice M012) and provide Form HCS-260A "Change Report Form" to:
 - a. All applicants at initial eligibility determination, redetermination, and any time a change is reported, or when a change is not reported timely,

- b. All households upon receipt of a change,
- c. Upon household's request, and
- d. At every opportunity when communicating with the recipient.

Applicant/Recipient: 2. Report any changes as soon as possible but within 10 days of knowledge of the change by completing Form HCS-260A, by phone, in writing, or in person.

- Eligibility Case Mgr:** 3. **Within ten days of the reported/discovered change**, take appropriate action prior to cutoff (issuance of benefits) to assure issuance of correct benefits and avoid overissuances.
4. Send ADEQUATE notice if the recipient reported the change on a signed Form HCS-260A and provided enough information to accurately determine ongoing eligibility. Send TIMELY notice for all other instances of adverse action.
5. Give the recipient a new change report form for future use.

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