COMBINED MEDICAID 103-1
Application, Eligibility Determination & Furnishing Assistance

Supersedes: CMA 103-1 (11/15/2024)

Reference: 42 CFR 435.905-909, .911-914, .916(b)(2)(iii); .945-.956, 42 CFR 457.330; ARM 37.82.101, .201, .204-.206, & .904

Overview: Anyone who wants to apply for Medicaid must have the opportunity to do so without delay. Applications must be voluntary and initiated by the person in need, their authorized representative, or if the applicant is incompetent or incapacitated, someone acting responsibly for them. If the applicant voluntarily withdraws the application, document in case notes with the withdrawal reason and send About Your Case' denial notice.

APPLICATION FORM:

The application must be a form prescribed by the Department, or a single streamlined application for all insurance affordability programs developed by the U.S. Department of Health and Human Services. The applicant must attest to the truth, accuracy, and completeness of the information provided and declare that they understand that any misinformation will be investigated and prosecuted.

APPLICATION DATE:

Unless received after hours, the Medicaid application date is:

- Paper application: date the signed application or first page is received and date-stamped in a field office or central scanning.
- Faxed application: date of the fax, or if received on a weekend or holiday the next business day
- Online application: date the application arrives in the online application mailbox.
- Telephonic application: date the client completes the telephonic application.

All applications (paper, fax or online) received after normal business hours, are considered received and date-stamped with the following business day's date.

PLACE OF APPLICATION:

Individuals can apply at any field OPA, by mail, telephone or online. Field offices must allow individuals to drop off or pick up applications at any time during regular working hours and days, including the lunch hour.

COMPLETE APPLICATION:

Applicants can submit a signed first page of an application to establish their application date. Medicaid cannot be approved or authorized until a completed and signed application is received.

RECEIVING MEDICAID IN ANOTHER STATE:

Medicaid must be closed in the state the client moved from before a Montana Medicaid application can be approved. Medicaid can only overlap for a one-month period when a person moves to Montana and was receiving Medicaid in another state.

ELIGIBILITY INVESTIGATION:

A signed application authorizes an investigation to determine eligibility. Investigations include securing reasonably available information (e.g., income statements, medical bills, etc.) and gathering information from other sources including Universal Inquiry. The agency's goal is not to prove or disprove eligibility, but rather to investigate information, determine eligibility if enough information is present, and render a decision.

ELIGIBILITY DETERMINATION:

Each decision is supported by facts documented in the case file, and a decision is rendered in each case within:

- 90 days for applications requiring a disability determination; and
- 45 days for all other applications.

Time frames begin on the application date and end the day a decision notice is mailed to the applicant/authorized representative.

These time frames are not used as waiting periods before determining eligibility. Once necessary information is submitted, the agency cannot delay the eligibility determination. The time frames are limits on the agency, rather than allowances for the agency.

Medicaid cannot be denied simply because necessary verification is not provided within 45 days (or 90 days, as applicable) of the application. These timeframes can be extended based on continued communication with the client. See 'Extension Requests' below.

EXTENSION REQUESTS:

As long as the individual is making appropriate attempts to obtain verification and requests an extension prior to the 45th or 90th day timeframe, 15-day extensions are granted. Additional extensions must be requested prior to the current extension expiration date.

Case note all contact(s) with applicant and their attempts to obtain information. A new 15 day notice is needed each time the agency grants an extension and should list any outstanding verifications required.

WAIVING TIMELY DETERMINATION:

The 45-day processing time frame may be extended if the agency is unable to make an eligibility determination because of circumstances beyond the agency's control (e.g., the applicant is having problems obtaining necessary verification). The agency is not obligated to extend this 45-day period if the applicant has failed to respond (without good cause) in a timely manner to the county's request for documentation and verification necessary to determine eligibility. All processing delays must be fully explained and documented in case notes. Each extension requested by the applicant and granted by the agency must be documented with a new 15-day notice to the applicant.

ELIGIBILITY START DATE:

Eligibility begins the first day of the application month for applicants who are:

1. Categorically needy; or
2. Medically needy and choose and pay the 'cash option' or
3. Eligible for MWD and pay the cost share.

For medically needy applicants who choose to use incurred medical expenses to meet the spend down obligation, eligibility begins the day the client has enough medical expenses to meet the spend down. This may or may not be the first day of the month.

NEW COVERAGE REQUEST:

A request to add another household member to an existing/open Medicaid case is considered a new "coverage request"; **a new application cannot be required**. The new "coverage request" is considered a reported change and is subject to change reporting timeliness requirements. When a household reports a new household member, the household must be given only 15 days from the "coverage request date" to provide information necessary to determine the individual's eligibility, as well as to redetermine eligibility for the existing household members' continued eligibility, which may be affected by the addition of the new household member.

A denial notice is sent for the new and/or existing household member if adequate information to determine their eligibility is not provided within the 15-day period, as well as a closure notice for any existing household members whose eligibility cannot be determined without the information about the new household member. The new "coverage request" is not considered a new application, as Medicaid is already open for some household members.

The “application date” for an additional program or person is the date the coverage request is received.

CHANGES BETWEEN MEDICAID PROGRAMS:

If a recipient of one Medicaid program requests a change to another Medicaid program, a new application **CANNOT** be requested or required. If the case file contains sufficient information to determine eligibility for the new program, no additional information is requested. A redetermination/renewal form may be used to gather information, although failure to complete a redetermination form is not a reason for denial if all necessary verification is provided. In the case of changes to HCBS waiver or institutionalized Medicaid, use of HCS-463, "Nursing Home Redetermination" form is recommended in order to gather information about asset transfers during the look back period.

When someone who is in the home (or joins the household) but not receiving Medicaid (such as a parent) requests Medicaid coverage, a new application cannot be required as long as there are other family members receiving Medicaid at the time coverage is requested. If an individual joins the household, the household composition change must be reported. Eligibility factors are evaluated according to the program requested. The following may be used to report this change:

1. HCS-261A (Adding a New TANF or Medicaid Household Member);
2. HCS-272M (redetermination/renewal form);
3. HCS-260A (change report form);
4. Self-Service Portal, ‘Report My Changes’; or
5. Verbal report, either in person or by phone

EX PARTE REVIEW:

When an open Medicaid case is closed for any reason other than at the request of the recipient, the case must be reviewed for eligibility for other Medicaid programs. This process is referred to as an exparte review and *must* be case noted for each Medicaid closure.

Whenever possible, an exparte review should be based on the information already available in the existing case file. However, if changes have been reported but not verified by the household, if additional eligibility factors must be evaluated for other

Medicaid programs, or if financial information in the case file is not reasonably current, verification of the additional or updated information must be requested from the household or obtained by the eligibility case manager before the exparte review is completed.

It may be helpful to obtain a completed Medicaid redetermination form from the household to use as a tool in determining eligibility for other Medicaid programs. However, the household's failure to complete and return a completed Medicaid redetermination form in an exparte process is not a basis for denial of Medicaid benefits.

If the case is found to be eligible for another Medicaid program during an exparte process, the "new" Medicaid program should be opened. The household must not be instructed or required to reapply for benefits before the "new" Medicaid program can be opened. Before opening a medically needy program, contact the client to determine if a need exists.

If the household fails to provide proof of previously reported changes or the eligibility staff member is unable to obtain the verification independently, the exparte review is considered complete. Case note the exparte process and the outcome.

PROVIDER NOTICE OF ELIGIBILITY DETERMINATION:

Providers can bill and receive payment for services up to 365 days after the date Medicaid eligibility is authorized, or the date of services, whichever is later. When the 365-day billing window has expired (or is nearly expired) prior to Medicaid authorization, the eligibility staff member creates and sends the provider notice of eligibility determination notice to known providers. The provider notice of eligibility determination may also be used when eligibility is approved retroactively.

Certain services (such as ambulance services or psych-related services) require pre-authorization. If Medicaid is not authorized prior to the date of service, a provider notice of eligibility determination notice is required for the provider to receive Medicaid payment. The notice is not completed when:

1. Medicaid was open at the time of service, but the provider failed to bill timely, or
2. The Medicaid client did not tell the provider he/she had Medicaid coverage when the services were provided.

REAPPLICATION:

When a case has been correctly closed and the effective date of closure has passed, a new application is needed to reinstate Medicaid coverage. Reapplications are processed in the same manner as original applications.

When a Medicaid application has been denied due to failure to provide the requested verification and the individual provides **ALL** the verification(s) within 90 calendar days from the denial notice, a new application is not required. The effective date of coverage is the date when **ALL** verification(s) were received.

When a Medicaid application has been denied for reason(s) other than failure to provide the requested verification(s), a new application is required (even if it's within the 45 days of the original application date). The original application has already been processed and is no longer valid.

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