2220.05.00 CHANGES REPORTED AND VERIFIED TIMELY

When a change is reported within 10 days of the date the change occurred and is also verified within 13 days of the report date, action is taken as indicated below.

When a change results in a positive action or increases the level of benefit, including the addition of a mandatory AG member, the effective date of the change is the month following the month the change was verified. If the Eligibility System does not form the new benefit of as of the first following month, then the case should be reviewed for a possible fiat or override.

Positive changes are changes that will increase the level of benefits and include verification that a member moved into a nursing facility, reductions in income and additions to the household. If a reported change is received stating that a member moved into a nursing facility, this is considered a verified change. If all other eligibility criteria are met (including the data gathering interview, all verifications received etc.), then the MA D category change will take place going forward to the next month.

Example 1:
On 03/01, a healthcare application is received for a disabled applicant; the applicant does not receive SSDI or SSI and there is no MRT determination. The applicant/AR is requesting dual processing for HIP and MA D.

On 03/15, the HIP is approved, and the POWER account is paid; the HIP is open 03/01.

On 03/27, verification that the member moved into a nursing facility is received, but the case is still pending a disability determination. On 04/02, MRT approves the MA D, and the case is authorized. Due to adverse timeframes, the HIP is ending 04/30 and the MA D is opening 05/01, but because the reported change of residing in a nursing facility was received 03/27, then the MA D should open 04/01. In this situation, the worker sets up an override /fiat to end the HIP effective 03/31 so a fiat or override can be completed for MA D starting 04/01. The HIP will remain in place for the month of March.

Example 2:
On 03/01, a healthcare application is received for a disabled applicant; the applicant does not receive SSDI or SSI and there is no MRT determination. The applicant has a pending waiver application. The applicant/AR is requesting dual processing for HIP and MA D.

On 03/15, the HIP is approved, and the POWER account is paid; the HIP is open 03/01. The waiver approval is received 03/25, and on 04/27, MRT approves the MA D.

Due to adverse timeframes, the HIP is ending 05/31 and the MA D is opening 06/01, but because the waiver approval was received 03/25, then the MA D should open 04/01. In this

situation, contact the Help Desk/PAL to end the HIP effective 03/31 so a fiat or override can be completed for MA D starting 04/01.

Example 3:
On 07/25, an individual reports that their last day of work was 07/18 and the last paycheck will be received 07/26. The recipient provides a statement from the employer on 07/30 (within the 13-day guidelines). The earnings are removed from the budget effective 08/01 and any increase in benefits will take place in the 08/01 budget, even if the authorization occurs after adverse.

If the AG's benefit level decreases, or the AG becomes ineligible because of the change, the decreases in the benefit level is effective according to the normal adverse processing guidelines. Using the same example as above, if the change was verified on 07/30, then the decrease in benefits would take place in the 09/01 budget.

See IHCPPM 4205.10.00 for information on Appealable Actions.

There are several exceptions to this, including the following:

- For individuals who become pregnant and are receiving coverage for Family Planning Services under MA E, if the individual reports that they are pregnant, eligibility for MAGP will need to be determined and coverage may be granted retroactively without requiring another application being filed. In such situations, the appropriate DFR staff member would need to create the new category with an override/fiat, if appropriate, to end date the MA E coverage so MAGP coverage could be granted.

- For an ongoing MA I recipient, if the member enters a nursing facility or is approved for a waiver, a review of the retroactive MA months should be completed to verify if the recipient is eligible for a full coverage category. After a thorough review of both income and resources is completed, and it has been determined that the recipient is eligible for retro months, then the assigned DFR staff member would need to create the new category with an override/fiat, if appropriate, to end date the MA I coverage so the full coverage MA could be granted.

- When a member reports a change after adverse that changes their PAC amount, the PAC changes will follow Adverse processing rules. This is because the member's Managed Care Entity (MCE) does "prospective billing" for POWER Account Payments, which means the member will have already been invoiced for following months. To reduce member confusion and possible system issues the new PAC amount, whether positive or negative, will not go into effect retroactively and does not need to be adjusted for current or past months.

  The PAC change will be effective using normal Adverse (see 2232.00.00) rules if it is a negative change.

If the change is positive, it will be effective as of the next recurring month of eligibility that the system forms ("Recur"). If there are fewer than six days left in the month, the system has already formed the benefit for the immediately following month and will push the change forward.

Examples:

- A member reports an increase in income, and it is verified on 5/20. The MCE has already sent invoices for May and June coverage. Using normal Adverse rules (see 2232.00.00), the new PAC amount will go into effect 7/1.
- A member reports a decrease in income, and it is verified on 5/1. The MCE has already sent the invoice for May coverage. Using normal Recur rules, the new PAC amount will go into effect 6/1.
- A member reports a decrease in income, and it is verified on 5/29. The MCE has already sent the invoices for May and June coverage. Using normal Recur rules, the new PAC amount will go into effect 7/1.

If an ongoing HIP AG is determined eligible for a MED 1 or MED 4 category, then change processing guidelines must be followed. If the category change is processed after adverse, but before the end of the month, then please create the new category with an override/fiat to remove the ongoing months of coverage. Retro months cannot be removed.

In situations of dual processing, it is important to inform the applicant/AR that HIP coverage will not be removed for prior approved and fully open (not conditional) coverage. For applicants that are in a nursing facility or are in the process of being approved for a waiver, it is best practice to pursue the MA D process as opposed to processing for HIP coverage.

If a recipient is in a nursing home and was on HIP, a deviation can be completed for medical expenses incurred in a retro month that the recipient was eligible for HIP coverage, if the claim was not a HIP covered service. See IHCPPM 3455.15.10.

It is the provider's responsibility to work with the Managed Care Entity (MCE) regarding billing issues, up to and including obtaining prior authorization. If a provider was denied prior authorization or a bill was denied by the MCE, the provider must exhaust all grievances and appeals with the MCE before requesting the HIP removal. If the provider disagrees with the MCE determination, then this should be appealed with the MCE, not with the DFR.

If a request to remove pre-existing HIP coverage is received, then the removal will be reviewed on a case-by-case basis. If an actual provider generated bill, or copy of such a bill, is submitted that clearly shows that the provider has billed the Managed Care Entity (if applicable), that the claim was denied, and that the provider has exhausted all appeals and grievances with the MCE, then these can be reviewed by PAL for possible HIP removal; HIP removal is not guaranteed. Please send to PAL for a policy determination.