

**NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BISMARCK, NORTH DAKOTA
July 1, 2014**

IM 5213

TO: County Social Service Directors
County Eligibility Workers
Economic Assistance Policy Regional Representatives
Economic Assistance Policy Quality Control Reviewers

FROM: Julie Schwab, Director, Medical Services Division

SUBJECT: **Action on Reported Changes**

PROGRAMS: Medicaid, Healthy Steps

EFFECTIVE: July 1, 2014

RETENTION: Until superseded

SECTIONS AFFECTED: **510-03-90-10, 510-05-90-10 and 510-07-50-10**

This supersedes IM 5199.

The waiver allowing us to not react to increases in income reported by a household expires June 30, 2014.

That means that changes reported from January 1, 2014 through June 30, 2014, AND changes thereafter must be assessed for their effect on benefits ongoing from August.

If the worker cannot remember which individuals or cases reported changes between 01-01-14 and June 30, 2014, the individual's eligibility from August 1, 2014 through their next review will need to be evaluated at their next scheduled review. If the change would have resulted in a change in coverage starting August 1, 2014, the circumstances will need to be evaluated to determine if there is an overpayment. Likewise, as with pre-ACA Medicaid, if the household failed to report a change and it is discovered later, the circumstances will need to be evaluated to determine if there is an overpayment.

Just as before, under traditional (pre-ACA) Medicaid, clients are to report changes in income, household size, employment, residence, new---tax filing status, etc. within 10 days of their knowledge of the change. 10-10-10 requirements apply to ACA Medicaid as it always has to traditional (Non-ACA) Medicaid.

Because every household's circumstances are unique, all changes must be reported and reviewed, and it will depend on those circumstances whether it affects the client's benefits.

Under ACA Medicaid, clients will no longer be required to monthly report, but are required to report changes that may affect their eligibility, such as those itemized above. A revised change report has been created, which is currently being generated electronically. This is for the client's reporting convenience and does not require the individual to submit their changes monthly. There is no dollar amount or percentage threshold, all changes must be reported.

Following are some examples:

1. In March 2014, client reported that she is working extra hours until her employer replaces an employee who walked off the job. Client reported in May that the extra hours have ended. Since the waiver allowed us to not react to increases in income reported by a household, and the extra hours ended in May prior to the waiver ending, they will not affect the ongoing benefits. Worker should narrate this and the case would not have to be reworked.
2. In April 2014, client reports a job change and her income has doubled. Client had already been referred to the FFM, but her children are on ACA Medicaid and on Healthy Steps, so all are CE eligible through December 2014. Since the only eligible individuals in the household are CE eligible, worker should narrate the reported income and that it will not affect the children's eligibility until their review in December. Note that if the job change occurred in July or September, the action would be the same.
3. A Pregnant woman reported she received a promotion in May. Her baby was born in June. The baby is eligible for extended Medicaid for one year, through May of 2015. The pregnant woman is eligible for the 60 free days of extended MA through August. The worker would need to track the 60 free days and review the change in August when working September, to determine Mom's ongoing MA eligibility.
4. Client reported in June that she began working more hours in May. Client has been eligible under the parent-caretaker group. Worker will need to complete Magi-in-the-Cloud and use the new income when working the

benefit month of August. Depending on the amount, the change may have no effect on their benefits, or may change the client's eligibility from the parent-caretaker group to the Adult Expansion group or even result in closure of the parent-caretaker's eligibility depending on the amount of income. The children, however, will remain eligible through the end of the CE period. At that time, the reported change in income will be used to determine the children's ongoing eligibility.

- We must not impose a threshold on what the household reports, or how often. In some cases, a \$20 increase in income can make someone ineligible, in others; it may be a few thousand dollars. It all depends on the situation.
- Remember all adverse actions other than those specified at 510-05-25-25 require a 10-day notice. This includes:
 - Losing coverage/closing a case
 - Moving from Healthy Steps or Medicaid to the Expansion Group
 - Moving from Medicaid to Healthy Steps
- Overpayments will be calculated in much the same way as we do today:
 - If worker error, no overpayment is calculated or assessed.
 - If client error due to late or non-reporting
 - Determine which month(s) are in error
 - Determine whether Medicaid paid anything for the individual(s) during these months.
- **Example:**
 - Individual did not report an increase in monthly income of \$500.
 - If there are only children in the case and they are CE eligible, there is no overpayment (but client needs reminder of reporting requirements).
 - If the change does not affect the individual or household's eligibility, there is no overpayment, (but client needs reminder of reporting requirements)
 - If the change DOES affect the individual's eligibility, such as the individual was originally approved for ACA Medicaid under the parent/caretaker group, the children's group, or the pregnant woman group, and, had the income been properly reported, the individual should have been approved under the Adult Expansion Group, or Healthy Steps, the difference between what Medicaid paid out for that individual and the premiums paid for that individual would be an overpayment.
 - If the reported change would have made the individual ineligible under any of the Medicaid or Healthy Steps coverages, including Expansion, the overpayment would be equal to the amounts paid out during the months that would have been ineligible.

- Note that Healthy Steps overpayments are treated differently.....the premiums are recouped from the carriers (currently Blue Cross and Delta Dental). The carrier then recoups what they have paid the providers for the individual, then the providers bill the client.
- The treatment of Sanford overpayments will be the same as that for Healthy Steps, except that treatment of those for which Medicaid pays Fee-for-service (usually THMP and current month) is still under discussion. If you have these situations, contact the Medicaid Eligibility Unit at the state office.

Entering Changes in Circumstances in the Mini-app:

If the reported change will affect an individual's eligibility for future months:

1. Enter an end date for the eligibility span considering the advance notice requirements.
2. DO NOT overwrite the start date of existing spans.
3. Create a new determination,
4. Be sure to record the changes, and the new MAGI in the Cloud if appropriate.
5. Narrate and create and send the notice.