2235.00.00 CHANGES IN CATEGORY OF ASSISTANCE (CLEVIDENCE RULING) (MED)

When a Medicaid member loses eligibility under their current category of assistance, eligibility under all potential categories must be explored. If the case record contains information that a member is potentially eligible in another category, a new pending category will be formed by the Eligibility System according to the member's recorded information reflected in their case file and the Medicaid categorical hierarchy (see IHCPPM 2035.30.00).

If there is no information indicating possible eligibility under another category, Medicaid is to be discontinued. If the member is found to be ineligible in the newly formed category, Medicaid is to be discontinued. When eligibility is to be discontinued, a discontinuance notice is mailed to the member, which contains a list of all applicable categorical groups. If the client supplies information indicating potential eligibility under another categorical group prior to the member's effective date of discontinuance, Medicaid eligibility must be reinstated while eligibility under the new potential category is being determined.

When a change is reported that results in a potential new Medicaid category, Medicaid benefits continue without interruption. If the person is required to pay a CHIP or MEDWorks premium, continued eligibility is conditional upon the first day of the first month the premium categorical coverage begins. Whenever there is an adverse action, members must be given timely notice before the effect of the adverse action takes place. Please, refer to IHCPPM 2232.00.00.

MEDICAID MUST NOT BE INTERRUPTED WHILE A DETERMINATION IS BEING MADE CONCERNING THE MEMBER'S ELIGIBILITY IN THE NEW CATEGORY.

If an individual self-attests to being pregnant (refer to IHCPPM 2426.00.00), then eligibility may be considered under that category. For ongoing members (including those authorized conditionally), once pregnancy is reported there should be no closure for income considerations until after the end of the postpartum period.

Additional Information Needed to Determine Category Changes: If the eligibility status for a member under a new category is pending because of missing verification(s), the worker must send the Medicaid Category Change Form, FI 0017, to the member. Form FI 0017 must be completed by a worker and sent to the member with a 13-day deadline. If the additional information that is needed is more than what can fit on the FI 0017 Form, then an additional 2032 should be sent along with the FI 0017 Form. If the client fails to contact the DFR by the due date specified on Form 0017, Medicaid is to be discontinued. If the client contacts the DFR any time after receipt of the discontinuance notice and provides information which was specified on Form 0017, the client must come into compliance prior to the effective date of discontinuance to

have eligibility continued. (Refer to IHCPPM 2040.00.00). If the DFR is contacted after the effective date of discontinuance, the client will have to re-apply.

If the category change for an ongoing member is from one MAGI category to another, one non-MAGI category to another, or non-MAGI to MAGI; and the income is not questionable, income does not need to be requested again unless it is required for an active annual redetermination.

For category changes from MAGI to non-MAGI, or a change to add full coverage Medicaid to a Medicare Savings Program (QMB/SLMB/QI/QDW) only member, a data gathering interview must be scheduled to review current income, gather information on resources to include the lookback period (IHCPPM 2640.10.10), and (if applicable) determine disability status. If the missing information is related to blindness or disability not being verified (see IHCPPM 2412.10.00 and 2412.30.00) for the member, then DFR must conduct the Social Summary and collect Medical Evidence (refer to IHCPPM 2412.10.00 and IHCPPM 2412.30.05) for the preparation of the medical packet to be sent to MRT for a determination of disability or blindness (refer to IHCPPM 2412.15.15 and IHCPPM 2412.50.00).

Once a member responds timely providing additional information to continue eligibility and provides sufficient verification to determine eligibility under the new category, Medicaid eligibility continues without interruption. If the member provides information indicating possible eligibility under another category but does not provide sufficient verification, FI 2032 must be sent providing a 13-day deadline requesting the new verifications needed for eligibility determination under the new category. If the missing information is not returned by the due date on the 2032, Medicaid eligibility is to be discontinued.

HCBS Waiver Considerations: HIP will not pay for most institutional or HCBS waiver services.

If an ongoing Hoosier Healthwise child is in an institution or on an approved HCBS waiver and they are forming a HIP category due to turning age 19, a data gathering interview must be scheduled and the member should be explored for disability Medicaid. In this instance, the Hoosier Healthwise category should continue until eligibility is determined for disability Medicaid. If the member fails eligibility or fails to cooperate in establishing the MA D category, then HIP should be explored.

For ongoing HIP members, if HCBS waiver approval is received, a data gathering interview should be scheduled to determine eligibility for disability coverage.

Example 1:
A parent lives with her only child and receives MAGF. The child is seventeen and turns eighteen. The parent is no longer eligible to receive MAGF because she is no longer the caretaker of a dependent under 18. DFR notices that she previously claimed she was disabled but had never

had disability determined by MRT or SSA. A Form FI 0017 is sent to the parent and prior to the deadline on that form, she contacts DFR and re-claims that she is disabled. DFR conducts the interview to complete Form 251B, Determination of Disability Social Summary, and the worker requests medical records in accordance with IHCPPM 2412.30.05. Unless medical records are not timely received due to a failure by the member, Medicaid will continue until MRT renders a determination that she does not meet the disability determination. If MRT determines that she is disabled and she meets all other criteria for MA D, her coverage under MAGF will be discontinued but she will then be granted MA D coverage.

Example 2:

An ongoing MA 2 member with an approved HCBS waiver turns 19, and HIP is forming. HIP is not a waiver compatible category and will not pay for waiver services (IHCPPM 3310.00.00). Per Clevidence rules, the MA 2 should not be closed and a data gathering interview for disability Medicaid must be scheduled (IHCPPM 2005.00.00). The member complies with data gathering interview~~, agrees to apply for Social Security Disability~~ and completes the Social Summary. All documents are submitted including ~~verification of application with SSA and~~ medical records. MRT ~~provisionally~~ approves the disability, and the MA D is approved going forward.