2412.50.00 PROGRESS REPORTS AND ONGOING ELIGIBILITY (MED 1)

The policy stated in this section only applies to the MA D, MADW, MADI, and MA R categories of assistance.

When a Progress Report is required by the MRT or an ALJ, or when it is learned that the individual's disabling condition has improved, the caseworker must conduct an interview with the recipient, complete a new social summary, and obtain medical information following the same guidelines listed in Section 2412.30.05.

~~When a Progress Report is required, members aged 18 and over are required to verify that there is an active application or appeal on file with SSA. If this information is not known to the eligibility system, then a 2032 with a 45-day due date must be sent requesting verification. The 45-day timeframe begins the day the 2032 is sent requesting proof of application or active appeal for benefits with the SSA. Attempts by DFR to obtain medical documentation should not be delayed due to this requirement.~~

For members that are currently open in MADW, the MRT will determine if they are to remain eligible in that category or if they should transition to the medically improved category MADI. However, this would depend on whether they have medically recovered to the point at which the disability definition is no longer met. If the recipient remains eligible, another Progress Report may be required.

For an ongoing MA D, MADW, MADI, and MA R members, when the DFR is notified that SSA benefits have terminated due to loss of disability status, either by the SSA data exchanges or direct documentation, member's must be sent a 2032 to verify that a timely appeal with SSA has been filed. Per SSA guidelines, members have 65 days in which to appeal the denial. A pending verification form must be sent with a deadline date of the 65th day from the date the 2032 sent. Continued benefits must be verified by the SSA data exchange or by direct documentation issued to the beneficiary by the SSA. If SSA benefits based on disability continue due to a timely appeal, the Medicaid disability requirement continues to be met until the SSA rules on the appeal that the person is no longer disabled. In this situation, a new progress report is not needed.

Pending applicants for Medicaid under a disability category that receive an SSA denial are not eligible for the 65-day continuation period. Workers do not need to request verification of an appeal with SSA prior to taking action. ~~However, if prior to the denial action, the SSA interface shows an appeal has already been filed,~~ The MRT process can continue and if eligible the disability category can be approved, pending outcome of the SSA appeal.

When ongoing members are determined disabled by MRT and are approved for MA D, then subsequently denied disability benefits by the SSA because the SSA determined the person to not be disabled, members shall remain eligible in MA D for a minimum of 65 days from the date

the SSA was denied. If the member appeals the determination with the SSA within the 65-day period from the SSA denial, they shall remain eligible for MA D while the SSA appeal is being processed. This can be verified either by electronic verification or hard copy issued to the beneficiary by the SSA.

While the actual period to appeal is 60 days, The Social Security Administration allows an additional 5 days for the mailing of the decision notice which, in effect, increased the overall number of days disability applicants have to get their appeal to their local Social Security offices to 65 days.

Once a final determination regarding disability is made by the SSA, the decision is considered binding whether the appeal upholds the original SSA denial or is fully favorable to the member. If the SSA appeal decision finds that the individual is not disabled, the individual cannot be considered disabled for Medicaid purposes and will be explored for other categories of Medicaid assistance.

If an individual does not appeal the SSA determination within 65 days from the date the SSA denial, the determination of disability made by the SSA is binding, and the individual will not be considered disabled for purposes of Medicaid eligibility.

Medicaid under a disability category is to be discontinued with timely notice when a final determination decision is made by the SSA. Prior to any such discontinuance, consideration of eligibility in one of the other Medicaid categories must be pursued.