Version History Table			
Date:	**Document:**	**Changes Made:**	**Impacted Pages:**
2/2025	Retroactive Medicaid Process	- Added clarification about using the Tax/Hub. - Added clarification about the calculation of deductions. - Updated Pending and Processing section.	Pgs. 4-7
9/2025	Retroactive Medicaid Process	- Added a Table of Contents - Updated Verification Request (VR) sections to clarify that only 1 VR is needed for prospective and retro verifications. - Added CE clarifications if there is no prospective eligibility. - Added a process for when an ineligible month of Retro is requested.	Pgs. 2, 3,7, 8 and 9

Retroactive Medicaid Process Guide

Retroactive (retro) Medicaid is coverage provided for up to three (3) months prior to an applicant's initial application date. Retro Medicaid can be requested at any time within 6 months of the initial application date even if there was no indication of a need for retro Medicaid on the application or renewal form. The individual has 6 months from the initial application date to provide required verification and have retro Medicaid eligibility determined. See Appendix 477-000-017 - Retroactive Medicaid for additional information.

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Important Reminders about Retroactive Medicaid

- Retro Medicaid can be requested on an application or renewal form, on a Change Report submitted by the individual or verbally via a phone call.

- A retro Medicaid Program case **will not** be pended in NFOCUS until an eligibility determination can be completed (approval or denial).

- Staff no longer need to create a separate VR for retro when requesting information for retro and prospective eligibility at the same time. For additional information, please see *Section 5 – Verification Requests (VRs) for Retro Medicaid* below.
    - The due date of the VR (either 15 days or 30 days) will be dependent on if prospective/ongoing eligibily has been determined. For verification timelines follow the *Verification Requests* section of this document and the following MERL documents:
        - Policy Memo 25-02 Verification Request Due Date for Initial Applications
        - Policy Memo 25-02 Supplemental Guide
        - Date Calculator
    - **Suggested VR Wording**: *Retroactive Medicaid has been requested for (name) for the months of (list months). In order to determine your eligibility for Retroactive Medicaid, please provide the following verifications:*
        - *(list verifications needed to process).*

- Remember to add administrative roles (e.g., Authorized Representative, Guardian or Power of Attorney) to the separate retro Medicaid program case.
    - When the retro Medicaid program case is pended, staff must review and include any administrative roles from the pending or active Medicaid case.
    - If the role is not added, the case representative will not receive correspondence about the retro case.

- Once eligibility for retro Medicaid has been determined it is required that the individual and administrative role(s) receives a Notice of Action for the retro months.
    - A notice of action is **required** for any retro Medicaid eligibility request.
    - See the *Pending and Processing Retro Requests* and *Notice of Action (NOA)* sections of this document below for additional information.

- There is **no** retro Medicaid eligibility for 599 CHIP.

- For newborns, there is **no** eligibility for any months prior to their birth month.
    - If retro is being requested for a newborn for months prior to the birth month and the mother is not active or requesting Medicaid, follow up may be needed to determine if the mother is requesting labor and delivery coverage. If so, an application is needed for the mother.

- If retro Medicaid eligibility is for a child or otherwise CE individual (PW), continuous eligibility may be considered from the first month of eligibility in retro **if there is no prospective eligibility**. See the Continuous Eligibility Guide for further information.

1. Retroactive Medicaid requests:

- The individual is allowed 6 months from the date of application to request retro Medicaid and provide required verification(s). The worker will only review retro Medicaid eligibility for the months that were requested. If the individual only requested 1 month out of the 3 possible months, only the 1 month can be considered.

    - ***Example 1****:* An application was received on January 14, 2025 requesting retro Medicaid for October, November, and December 2024. Information is unable to be verified by utilizing the electronic verification sources and a VR specific to the information needed to determine retro Medicaid is sent. The information is not provided by the time the VR due alert is received. The retro Medicaid request must be pended and denied by the worker for '*Failed to Provide Information*' and the worker must send a notice of action. The individual has 6 months from January 14, 2025 to provide the necessary verification(s).
        - If the verifications are provided on or before July 13, 2025 then the retro Medicaid request must be processed.

    - ***Example 2:*** An application was received on January 21, 2025 with no retro request. The individual later requests retro Medicaid on March 1, 2025. Information is unable to be verified through electronic data sources and a VR specific to the information needed to determine retro Medicaid is sent. The information is not provided by the time the VR due alert is received. The retro Medicaid request must be pended and denied by the worker for '*Failed to Provide Information*', and the worker must send a notice of action. The individual has 6 months from January 21, 2025 to provide the necessary verification(s).
        - If the verifications are provided on or before July 20, 2025 then the retro Medicaid request must be processed.

    - ***Example 3****:* An application was received January 1, 2025. The client requested retro Medicaid on June 25, 2025 which is prior to the 6-month timeframe to request retro. The worker must send out a VR for information that was not able to be verified through electronic data sources. If the necessary information is not provided by the time the VR due alert is received, the retro Medicaid request must be pended and denied for 'Failed to Provide Information' and the worker must send a notice of action. The individual would not have a redetermination period to provide necessary information, unlike *Example 1* and *Example 2* above.
        - The reason for not allowing more time to provide information is the request for retro Medicaid was received near the end of the 6 months. If the information is received after the VR due date the retro Medicaid request **cannot** be processed.

NOTE: Retro Medicaid can still be requested on a previously denied initial application if it is within the 6-month timeframe from when the application was submitted. The determination for ongoing eligibility does not impact the agency's ability to review retro Medicaid.

2. Income for Retroactive Medicaid:

Earned Income:

- Determine if an electronic data source is available and it is reasonably compatible with the attested income. If the employment in the requested retro month(s) is the same as the current employment the individual attested to on the application **and** it's verified using electronic data sources, use the same income information for retro Medicaid months and the ongoing eligibility.
    - **Applies to both MAGI and Non-MAGI:** This process is used regardless of when the retro Medicaid request was made.
        - See **477 NAC 22-002.03(A)** and **477 NAC 16-001.14** for information.
    - **SEW:** The SEW interface can be used for both MAGI and Non-MAGI categories (except for Share of Cost) if it is reasonably compatible.
        - For additional information see: Policy Memo - SEW.
    - **Non-MAGI Share of Cost (SOC) exception:** For SOC, actual income must be used because SEW variances month to month could affect the SOC obligation.
        - See **477 NAC 22-002.03(A)** for additional information.

- Follow the Medicaid Income Handling Guide and Nebraska's 477-000-004 - Verification Plan/Verification and Document Guide – Earned Income.

    - **Tax/Hub (MAGI Only):** Unless the household has indicated that the income source is new, the Tax/Hub must be used as the first verification source. If the Tax/Hub verified the income in the initial application month, use the Tax/Hub for the retro months as well.
        - For a retro request made post application, review the Tax/Hub information that was completed at the time the initial application was processed. If the Tax/Hub verified the income at initial application, use the Tax/Hub for the retro request. If Tax/Hub did not verify income **do not** submit for new Tax/Hub information, move to the next verification source.

      Example (Tax/Hub): An initial application was received April 2, 2025, requesting retro Medicaid for the months of January, February, and March 2025. The attested income is from McDonald's with no indication that the income is new or that there has been a change. The attested monthly income is verified by the Tax/Hub for ongoing months. As such, the attested income must also be used in the retro budgets with the Tax/Hub as the verification source.

    - **VCI/TALX:** Actual gross income must be used for each retroactive month.
        - If a lead shows that the income may need to be annualized, additional follow-up would be required because income should also be annualized for retro budgets. **Reminder: Non-MAGI does not annualize earned income.**
    - **SEW:** Compare the attested income to the most recent SEW quarter. The most recent SEW quarter can be used even if the retro months being budgeted do not fall within the SEW quarter.
        - If a lead shows that the income may need to be annualized, additional follow-up would be required because income should also be annualized for retro budgets. **Reminder: Non-MAGI does not annualize earned income.**

Example (SEW): Initial application received May 2nd , requesting retro for the months of February, March, and April. When SEW is reviewed, use the first quarter, if available and reasonably compatible with attested income. If the first quarter is not available, review the fourth quarter from the previous year. If reasonably compatible, the fourth quarter from the previous year can be used as the verification source.

- **Paper Verification:** Actual gross income must be used for each retro month if electronic verification is not successful.
  - If unable to obtain all required information from the employer or the HH via a call out, generate a VR for actual gross income for each retro month requested.
  - For self-employment income, if a tax return is provided and determined reflective, the pro-rated annualized amount must be used in the retro budgets. If self-employment ledgers are provided, the actual amounts must be used for each of the retro Medicaid budgets.

Unearned Income:

- Follow Nebraska's 477-000-004 - Verification Plan/Verification and Document Guide.
  - Electronic data sources (e.g., BDE, SDX, IUC) are the first verification source for unearned income. If unable to verify via electronic data sources:
    - Attempt a call out to the source of income (e.g., Social Security Administration, Veteran's Administration hotline, retirement companies) for actual gross income.
    - If unable to obtain all required information from the source of income, send a VR to provide actual gross income for each retro month requested.

3. Deductions for Retroactive Medicaid:

- **MAGI**: To determine allowable MAGI deductions, refer to the MAGI Deduction Guide, WINK-ed MAGI Income Deductions and the *Deductions* section of the MLTC Processing Guide.
- **Non-MAGI:** To determine allowable Non-MAGI deductions, refer to Appendix 477-000-026 - Basic Budgetary Allowance for Non-MAGI and the *Deductions* section of the MLTC Processing Guide.

The calculation of the deductions must match the calculation method used for the income in the retroactive months. If a retroactive budget is approved using paystubs with "Actual Only" as the calculation method, deductions must match the actual amounts from those paychecks without converting them to a monthly amount.

***Example (Deductions)**:* Paystubs from 2/7 and 2/21 are received for an individual who is paid on a bi-weekly basis. The paystubs report allowable deductions. The 2/7 paycheck has a $50 deduction and the 2/21 paycheck has a $100 deduction. The actual amount from the 2/7 and 2/21 bi-weekly paystubs are used in the 2/2025 retroactive budget. The correct deduction amount is $150. Staff must not use the average/converted amount of $161.25 ($150/2 = $75 x 2.15 = $161.25).

4. Resources for Retroactive Medicaid (*Non-MAGI only*):

- To determine retro eligibility for a Non-MAGI individual, verify all countable resources and document on the case.
    - Follow the Medicaid Resource Verification Plan and AVS Procedural Guide.
        - AVS should have been requested at the time the initial application was received. AVS results will need to be reviewed.
    - Actual account balances are needed for each retro month requested.
    - Reduction of Resources can be used for excess resources and spent down on medical bills to obtain retro.
        - This can only be done if the individual has unpaid medical bills and is requesting medical assistance for the three (3) months prior to the initial application month (retroactive period).
        - The individual should pay the oldest medical bills in the retroactive period first. Appendix 477-000-034 - Resource Spend-Down

5. Verification Requests (VRs) for Retro Medicaid:

Verification Request due dates may be 15 days or 30 days, dependent upon whether the individual has established Medicaid eligibility. See 15-Day and 30-Day VR sections below.

If marking VR items as received would close the entire VR but further information is still needed for retro or prospective month, don't mark the VR items and narrate the items that were received and what remains outstanding.

15-Day VRs: Used when prospective/ongoing eligibility has been denied or has not yet been determined.

- If prospective eligibility was denied but the individual requested retroactive Medicaid on the application or later requests retro and a VR needs to be sent for information needed to determine retroactive Medicaid eligibility, **this VR due date must be set for 15 days.**
    - If retro Medicaid is for a child or otherwise CE individual (PW), continuous eligibility may be considered from the first month of eligibility if there is no prospective eligibility. See the Continuous Eligibility Guide for further information
- If verifications are needed at the same time for a prospective and retroactive Medicaid request, **one VR must be created**. The one VR must include all necessary verification for initial eligibility and retro eligibility. **The VR due date must be set to 15 days.**
    - If information is not provided for both initial eligibility and retro eligibility, leave the VRs open and deny the initial eligibility and retro eligibility.
        - Notice should include language for the 90-day redetermination period for the initial application and the 6-month timeframe for the retro eligibility request.
    - If information is provided for initial eligibility and **not** provided for the retro months, mark the VR items that were received and do not close the VR. The VR will be left open for the 6-month retro eligibility timeframe. Process the initial eligibility request and deny the retro eligibility request.
        - The individual has 6 months from the initial application date to provide required verification and have retro Medicaid eligibility determined.
        - If a worker identifies a VR that was left open for a retro request and it is past 6 months from the initial application date, the VR can be closed.

- If information is provided for the retro request and not for the initial eligibility request, mark the VR items that were received and do not close the VR. Process the retro eligibility and take appropriate action on the initial eligibility request.
  - If retro Medicaid is for a child or otherwise CE individual (PW), continuous eligibility may be considered from the first month of eligibility if there is no prospective eligibility. See the Continuous Eligibility Guide for further information.

30-Day VRs: Used when a individual has been approved for prospective/ongoing eligibility.

- If the individual has requested retroactive Medicaid on the initial application, but verifications are only needed for retroactive Medicaid requests because prospective eligibility has been approved, a VR must be created to request information for a retroactive Medicaid determination. **This VR due date must be set to 30 days.**
- If the individual did not request retroactive Medicaid on the initial application but later requests retroactive Medicaid after application month was approved, a VR must be sent for information for a retroactive Medicaid determination. **This VR due date must be 30 days.**

6. Pending and Processing Retro Requests:

If 3 months of retro Medicaid are requested and verification is received for only 1 or 2 of the months, the worker **can** process the months where all verifications have been received. The months with missing verifications would be denied.

- If retro Medicaid eligibility is for a child or otherwise CE individual (PW), continuous eligibility may be considered from the first month of eligibility if there is no prospective eligibility. See the Continuous Eligibility Guide for further information.

If all verifications are on file and Retro MED can be processed:

- Pend the Retro MED Program Case.
- Add any administrative roles to the Retro MED Program Case.
- Run budgets for all retro months requested in order to determine eligibility.
  - If the attested income is over the FPL, pend the case, enter the information into NFOCUS Expert to allow NFOCUS to determine eligibility, deny for Over Income and create a notice.
- Send notice to the individual(s) and administrative role(s).

In situations where NFOCUS does not allow a participant to be pended for a retro month, document in the narrative and send a generic notice. The worker must enter the appropriate NAC regulation that is applicable to the correct approval or denial reason. See the *Notice of Action (NOA)* section below for additional information.

If a VR is sent and all requested verifications are not received by the retro VR Due date:

- Pend the Retro MED Program Case
- Add any administrative roles to the Retro MED Program Case.
- Manually deny the Retro MED Program Case for "*Failed to Provide Information*" (FTP) and send a notice. **This should only be done after the VR Due alert has been received.**
  - If the retro Medicaid case is denied due to FTP information, eligibility for retro may still be determined any time within 6 months from the initial application date.

- A new application is not necessary as long as the verifications are provided within the 6 month timeframe from the application date.
- The initial VR for retro can be resent to the individual if needed.

If a request for retro is withdrawn by the individual:

- Pend the Retro MED Program Case.
- Add any administrative roles to the Retro MED Program Case.
- Manually deny the Retro MED Program Case for "*Client Request*" and send a notice.

If an ineligible request for retro is received:

Example: Application received in July and retro is requested for January, which is outside of the eligible 3 retro months.

- A Retro MED Program Case does **not need** to be pended and denied if the only month requested is a month which is ineligible for retro.
- Attempt a call out of the HH to verbally inform them they requested an ineligible month.
- If the PC attempt is unsuccessful, send a Generic Notice informing the applicant that they requested an ineligible retro month. Inclue the manual reference for Retro MED.

7. Notice of Action (NOA):

- Generate and review NOA.
  - If denying for the reason of "*Failed to Provide Information"*, staff may add comments to the NOA explaining what information is still required and the timeframe to provide.
  - Review that the NOA is also being sent to the administrative role if one has been designated.
- For retro Medicaid requests where regulation does not allow for a Medicaid determination or the Retro MED Program Case is otherwise unable to be pended or run, **the individual must still be informed of their eligibility**.
  - 599 CHIP - Retro Medicaid is not allowable for this Medicaid category.
    - If the request is indicated on the initial application or made post eligibility the worker must pend and deny eligibility for the retro request for the pregnant woman using the applicable reason (e.g., *Ineligible Alien*) and send an NOA.
    - See the 599 CHIP Process Guide for additional information.
  - Retro Medicaid request for months that an eligibility requirement is not met (e.g., residency or prior to date of birth).
    - If the request is indicated on the initial application or made post eligibility the worker must pend and deny the eligibility for the retro request using the applicable reason and send an NOA.

    Example*:* An application is received on 09/20/2024 requesting retro Medicaid. Information on the case verifies that the applicants moved to Nebraska on 09/08/2024. The HH is ineligible for any retro months due to not being considered Nebraska residents. The retro case would be pended and the individuals denied for Residency for each retro month. A system generated notice would be sent with the NAC references.

- Instances where the system does not allow a retro case to be pended (e.g., prior to the date of birth or the individual was already active in retro months).
    - If the request is indicated on the initial application, add an explanation to the comment section of the initial eligibility Notice of Action.
    - If the request is made post eligibility, send a Generic Notice to the individual informing them of their retro eligibility.
    - NAC references must be included on the NOA or Generic Notice.

  Example: A retro request is being made for a child prior to their birth month. A Generic Notice would be sent indicating that the newborn is not eligible for the months prior to their birth. NAC references for age requirements and age limits for Medicaid (**477 NAC 7-001**) would be included on the Generic Notice.