Version History Table			
Date:	**Document**	**Changes Made:**	**Impacted Pages:**
9/2024	MLTC Processing Guide	- Duplicate Application sections were updated with direction for sending a Generic Notice instead of denying the application for reason of "other".	Pgs. 7, 26
2/2025	MLTC Processing Guide	- Added note explaining how to calculate retroactive MAGI deductions when paystubs are used.	Pg. 19
5/2025	MLTC Processing Guide	- Added clarification that attestation can be accepted for MEC for dependent children.	Pg. 20
7/2025	MLTC Processing Guide	-Updated SE calculator link	Pg. 18
9/2025	MLTC Processing Guide	- Added link outs to the Medicaid Resource Verification Plan and the Resource Verification WINK-ed.	Pgs. 30, 35 and 40

MLTC Processing Guide

477 Medicaid Manual: The Medicaid 477 NAC manual has been moved to the Secretary of State's website: 477 MEDICAID ELIGIBILITY. Staff will need to go to the SOS website, click on the applicable chapter and search for the manual reference noted (Tip: Use Ctrl + F to bring up a search function).

HHA/MAGI Expansion: Effective with the December 2021 NFOCUS release, budgets are displayed as HHA Basic or HHA Prime however, all HHA/MAGI Expansion participants received full Medicaid benefits effective 10/1/2021. Effective with the April 2022 NFOCUS release, when running an HHA/MAGI Expansion budget it will appear in NFOCUS as "MAGI Expansion" or "MAGI EXPANS," depending on the screen being viewed. For HHA/MAGI Expansion budgets prior to 10/01/2021, it will continue to appear in NFOCUS as HHA Basic or HHA Prime unless a recent budget has been processed.

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IMPORTANT REMINDERS: Any federal tax information (FTI) received from the IRS data hub is strictly confidential. This information is not to be shared with applicant, individual and other parties. This information is not to be copied, stored, and/or printed. Please be aware that a signed application allows you to ping the federal Tax/Hub initially.

Reminder: When a Verification Request is due, allow for the *VR Due* alert to generate before taking negative action.

MAGI Eligibility Processing – New Application

1	**Begin:**	• Accept work task "Application Received" if applicable.
2	**Check for Valid Application:**	• Check for a valid application: containing name, address and signature. (see **477 NAC 3-005**). For MAGI, we would accept the *MILTC-53, HCNE, HCPH, and HCMP applications.* o If application is valid, go to *Step 3* in this section. o If application is not valid, take appropriate steps to obtain a valid application. ▪ See the Stand Alone Application Chart for information on proper applications. ▪ See Valid Application Signature for information on valid application signatures. ▪ Utilize the MLTC Consent Line Process Guide for applications missing a signature. o Attempt to contact the individual by phone for follow-up if areas on the application are left blank or where clarification is needed. See Unanswered Questions for further information. • **Former Foster Care** - Refer to Former Foster Care Guide for further information when the application indicates that an individual was previously in Foster Care, in ***any*** state, and is under age 26. • **Incarcerated Individuals -** Applications ***must*** be accepted and Medicaid eligibility determined for individuals who are residing in a 24 hour facility that are being discharged either the month the application was submitted or the month after the application was submitted. *Examples of these facilities include* Youth Rehabilitation and Treatment Centers, Regional Centers, Department of Corrections facilities, County Jails, and County Youth facilities. *IMPORTANT NOTE:* The SUPPORT Act of October 2018 added a provision that applies to applications received for juveniles (defined as individuals under age 21 and individuals who may be eligible under Former Foster Care). The state is required to accept and process applications for individuals up to age 26 at any point during their period of incarceration. o **Universal Staff Duties -** For any application received where an individual indicates they are incarcerated, staff must assign the case to the **INC ASSIST** position number (66118075). See Medicaid Position Numbers for Case Assignments for further information. o **Assigned Staff Duties** – Verification of the release date from the facility is required prior to processing the application. Verifications can be provided from staff at the facility. The assigned worker will also need to know where the individual will be residing upon discharge, household composition, tax household information, and verification of income of any individual who would be financially responsible for the client based on the tax filing status.

3	**Compare Application to System**:	• Review NFOCUS entries with information provided on current application (see also the MAGI Initial Processing Checklist). If information does not match, make corrections to the information in NFOCUS: o Screen for Duplicate Application (see below) o Screen to determine if the application is considered a renewal form (e.g., case was previously closed less than 90 days ago during the review process for not providing a renewal form). See 90 Day Redetermination Examples for further information. o Voter registration requested (see the Voter Registration SOP). o Comments section. o Address (physical and mailing), telephone and email information. o Notification preferences: mail, email, text (SMS). o Correct applicants pended? o Tax Household and Tax Permission. o Screen to ensure application is a MAGI application and review for age. o Add Authorized Representative, if listed. o Review for Retroactive Medicaid request. Follow steps in the Retroactive Medicaid Process. o Review Sanctions. o Review Work Tasks and Alerts. • **Duplicate Applications** – o A duplicate application is an application that is: 1. received on an active case participant with no review due; or, 2. received within 90 days of the closure or denial date. o Duplicate applications received must be reviewed for changes and action taken on these reported changes. See Duplicate Applications and "Is a New Medicaid Application Needed?" for further information. o **Once an application has been identified as a duplicate, the following steps must be taken:** 1. If the case was pended, deny the pending case for 'Other' and send a notice. 2. If the case was not pended, a Generic Notice must be created. 3. Include comments on the Notice: ▪ Manual reference **477 NAC 3-005.06**. ▪ Explanation that the application is being denied as it was identified as duplicate. ▪ Inform the applicant of verification(s) needed to complete determination and the deadline for the 90 days, calculated from the date of the original application. o TOOL: Calculator for Days 30, 45, 60, and 90.

		4. Check Program Case Mode: it may be necessary to update it to Change Management. 5. Change the application tie reason from initial to duplicate. ▪ From the detail master case window, select the program applications. ▪ Highlight the duplicate application window and select update. ▪ Change the application reason from initial to duplicate. • **Active Individuals** – If an individual is active in a Medicaid program case and would be transitioning to a different Medicaid category, a new application is not required. Application forms can be used as a tool for staff to obtain information from an active individual however, it cannot be a required form that the agency obtains, **unless it is at the applicable renewal time**. o *Example #1:* Individual is in MAGI Expansion and begins receiving Medicare. The individual needs to be reviewed for eligibility in a Non-MAGI category. A new application may be helpful to obtain attestation of resource information but cannot be required of the participant. o *Example #2:* Individual is over income for a MAGI category and does not meet eligibility for a Non-MAGI category. The worker is reviewing for MN/PC eligibility. A new/supplemental application may be helpful to obtain attestation of resource information but cannot be required of the participant.
4	**Social Security Number (SSN):**	• Check applicant's blue SSA interface to ensure they have HUB SSN Verified. o If not verified, first check demographic information (name, DOB and SSN) has been entered correctly in NFOCUS. o If further clarification is needed after comparing with the application, call the individual. o If call to individual does not resolve the issue, send a VR for the social security number. Do not request copies of Social Security cards from individuals. • Medicaid recipients must have a valid Social Security Number **except for the following**: o Infants less than a year old who were born to a Medicaid eligible mother. o 599 CHIP & EMSA participants. o Applicants with a "Well Established Religious Objection". o An individual that is not requesting Medicaid is not required to provide their Social Security number. • For individuals who **DO NOT CURRENTLY** have a Social Security Number and the SSN is the only item needed to process - process the application. If approved, create a VR informing the individual they have 90 days from date of application to provide a SSN or verification that they have applied for a Social Security Number with the SSA. The VR due date must be set for 90 days from the date the VR is being sent.

5	**Citizenship & Immigration:**	• Check that all applicants either have verified U.S. citizenship or verified eligible immigration status. If citizenship or immigration status has not been verified, submit all applicants for verification: o The Citizenship and Immigration screen (*Actions* menu > US Citizenship and Immigration) and the blue SSA interface can be reviewed for citizenship verification. o The VLP interface can be reviewed for eligible immigration status. • **Reasonable Opportunity (RO) Period:** If the applicant attests to being a US citizen or having a Medicaid eligible immigration status that cannot be verified because (1) there are no available electronic data sources, (2) VLP is in Step 2 or 3, or (3) paper verifications are being requested; process the application as long as all other points of eligibility have been verified. The individual(s) must be notified of the reasonable opportunity period on the Notice of Action. See Reasonable Opportunity Period and Reasonable Opportunity Examples for more information. o If additional information is needed from the applicant to verify citizenship or immigration status (e.g., copies of documents), send a VR for the information to be returned. The VR due date must mirror the time allowed for the reasonable opportunity period. o Staff **must** set a manual 95 day alert for the individual's ongoing eligibility to be reviewed. ▪ RO policy allows for the 90 day clock to start on the date the individual receives the notice (generally 5 days after the date of notice). o On the Approval Notice, notify the applicant of the reasonable opportunity period using the language below. If an approval notice is not generated, send a Generic Notice with comments about the 90 day reasonable opportunity period, using the notice wording below. A notice is required to ensure the individual receives rights and responsibilities. **RO Notice Wording:** *Citizenship or non-citizen status has not been verified for (NAME). A 90-day reasonable opportunity period (**477 NAC 5-006**) has been applied for the Department to conclude the electronic verification process and/or the applicant to provide the satisfactory citizenship or immigration documents. Retroactive Medicaid cannot be authorized during the reasonable opportunity period (42 CFR 435.956(a)(5)(iii)). If citizenship or non-citizen status has not been verified by (DATE; use the calculator on MERL), Medicaid benefits will be terminated.* • **Refugees:** If it is attested or verified that an individual is a refugee, staff must determine if the individual has been in the country for more than 12 months or less than 12 months. See the Refugee Process. o Individuals verified as refugees who have been in the country for **12 months or less** should be assigned to the Refugee Medicaid Referral position number (87055714).

	***Cont.* - Citizenship & Immigration:**	○ Individuals verified as refugees who have been in the country for **more than 12 months**, must be processed by the worker and are not assigned to the position number. ▪ Review the Citizenship/Immigration task in the Expert system. If *Refugee Resettlement Program (RRP)* is listed, this is not a valid Medicaid immigration status and must be updated to the current immigration status or REF207 before processing any budgets. • **EMSA:** If no immigration status is indicated, consider eligibility for Emergency Medical Services Assistance (EMSA). See the EMSA Process Guide for further information. • For any situation where SAVE was utilized to verify immigration status, the SAVE documents need to be uploaded to Document Imaging (DI). • **Process Guides and Tools:** ○ MLTC Citizenship and Immigration Guide ○ Qualified Non-Citizen Status Eligibility ○ How to submit G845: G-845 Immigration Documentation Process
6	**Family Relationships / Household Composition:**	• **Family relationships must be established prior to running any budget. Correct family relationships are key to NFOCUS identifying financial responsibility and the correct unit size.** • Attestation of family relationships are acceptable and must be narrated. ○ If information provided is questionable/different from information known to the agency, verification of family relationships may be needed. Family relationships can be verified: ▪ Electronically - Vital Statistics (VS), CSE interface, VLP interface (COA codes), or; ▪ Through paper documentation in Document Imaging (e.g., birth & marriage certificates, hospital birth records, birth registration worksheet, etc.). • If family relationships are not previously established in NFOCUS, complete family relationships in the Expert system. See the Tax HH and MAGI Budgets WINK-ed for more information. ○ **For attested relationships**, choose one of the following drop-down verification sources: '*other-document in narrative*,' or '*signed statement by person with knowledge'*. ○ **For verified relationships**, choose the appropriate verification source from the drop-down. • Review application for pregnancy. See the Continuous Eligibility Guide for further information. ○ If there is already an unborn on the case, check the Expected Date of Delivery in NFOCUS against the information on the application. ▪ If this is for a pregnancy that ended (e.g., Overdue), terminate the previous pregnancy.

	***Cont.* - Family Relationships / Household Composition:**	▪ Add a new pregnancy for the new Expected Date of Delivery (EDD). ▪ **NEVER** change the EDD on a previous pregnancy for a new pregnancy. o For applications that do not contain an estimated due date, use a default date of 6 months from the date of the application. o If the pregnant individual is requesting Retroactive Medicaid, attempt to reach individual by phone to obtain the due date to determine if they were pregnant during the retro months. If unable to reach the individual, send a VR with the following language: **VR Wording** - *In order to process your request for retroactive Medicaid for (Enter Months). Please contact us regarding your estimated due date. Please note that failure to provide this information could lead to denial of medical coverage for these months only. Thank you.* o After the application is submitted, if the individual indicates pregnancy in the month after the application date, and case has not yet been processed, they will need to be determined under MAGI Expansion.
7	**Tax Household & Tax Permission:**	• **Tax Household:** Set up tax HH as listed on the application for all household members that are identified as part of the Medicaid household. For assistance use the Medicaid Household Construction Chart. o Tax filing status can be accepted as declared on the application. o If tax HH is missing or unclear for any HH members, attempt a call to the HH to clarify. If unable to reach the HH send a VR requesting that the Tax Information Form (TIF) be completed for all members of the household. o If there is already an existing tax HH on the case that matches the information attested to by the HH on the application, a new tax HH **does not** need to be set up. Update the tax permissions from the application on the existing tax HH. **NOTE:** Tax permission and tax household for individual's age 19 or older needs to be provided by the individual, financially responsible family member, tax filer in the same tax household or authorized representative, POA or guardian. • **Tax Permissions:** Enter or update the signature date and number of future year(s) permission to the tax HH by clicking on "Tax Permission" button located in the "Detail Tax Household" screen. See Understanding Tax Permissions for further information. o **Paper applications** – The signature date is the date the individual signs the application. If the individual did not date their signature, the signature date is the date the application was

	***Cont.* - Tax Household & Tax Permission:**	○ received. Review and update the number of future years the individual agreed to. If the future year(s) permission is left blank, enter '0' in this field. ○ **Electronic Applications** – The signature date is the date the application was SUBMITTED. Review and update the number of future years the individual agreed to. If the future year(s) permission is left blank, enter '0' in this field. ○ **Tax Information Form (TIF)** – The signature date is the date the individual signed the TIF. Review and update the number of future years the individual agreed to. Unless otherwise noted by the individual, 5 years of permission is granted from a signed TIF. • **Pinging the IRS Tax/Hub (*only done on MAGI initial applications*):** After entering the tax HH, tax permission date and number of future year(s), click the "Submit to INTERFACE" button from the Detail Tax Household screen. ○ VCI/TALX should also be sent for all applicable participants at the same time, to speed up processing. ○ Pinging the Tax/Hub is not required for applicants who declare no tax filing status or applicants who declare $0 income. Staff should move on to other electronic verification sources (VCI/TALX, SEW). • **RESOURCES & TOOLS:** ○ Tax Household & MAGI Budgets WINK-ed and the Tax Household & MAGI Budgets Q&A. ○ Understanding Tax Permissions ○ Medicaid Household Construction Chart. ○ Tax Information Form ▪ If the form is signed: • The Signature Date must be updated. • The Tax Permission field in NFOCUS must be updated to 5 years, unless otherwise noted. ▪ If the form is not signed: • The Signature Date would not be updated. • Tax Permission field in NFOCUS must be set to zero ('0'). • We will not utilize the Tax/Hub to complete the next renewal.

8	**Living Arrangement:**	• All living arrangements are eligible to be processed as MAGI and Non-MAGI. • If Living Arrangement is in a facility or hospital – Is the individual age 19 or older? o **Yes:** determine MAGI Expansion eligibility. o **No:** Consider relative responsibility with others in household. Referral to AD Waiver or DD may be appropriate. • **MAGI Expansion: All Living Arrangements.** o Homeless, verified by attestation. Confirm mailing address. o Disabled by Social Security, not eligible for Medicare. o If the individual indicates disability on application and is not currently determined disabled by Social Security, refer to apply for Social Security. • All other living arrangements can be processed as MAGI without AVS information. See the Living Arrangement Guide for further information. • **Incarcerated Individuals -** Applications ***must*** be accepted and Medicaid eligibility determined for individuals who are residing in a 24 hour facility that are being discharged either the month the application was submitted or the month after the application was submitted. *Examples of these facilities include* Youth Rehabilitation and Treatment Centers, Regional Centers, Department of Corrections facilities, County Jails, and County Youth facilities. *IMPORTANT NOTE:* The SUPPORT Act of October 2018 added a provision that applies to applications received for juveniles (defined as individuals under age 21 and individuals who may be eligible under Former Foster Care). The state is required to accept and process applications for individuals up to age 26 at any point during their period of incarceration. o **Universal Staff Duties -** For any application received where an individual indicates they are incarcerated, staff must assign the case to the **INC ASSIST** position number (66118075). See Medicaid Position Numbers for Case Assignments for further information. o **Assigned Staff Duties** – Verification of the release date from the facility is required prior to processing the application. Verifications can be provided from staff at the facility. The assigned worker will also need to know where the individual will be residing upon discharge, household composition, tax household information, and verification of income of any individual who would be financially responsible for the client based on the tax filing status.

9	**Income Verification Plan:**	• Create a monthly budget. **When determining eligibility for any participant, ALL income must be verified using Medicaid's Income Verification Hierarchy. See the Medicaid Income Handling Guide for further information.** 1. **TAX/HUB INTERFACE:** This should be used as the first level of income verification on ALL MAGI Initial Applications. The Tax/Hub compares the attested income against the household's most recent tax return. a. Applications submitted for an individual on an already active case (add a person) may not use the Tax/Hub, except in certain circumstances - if the individual is being added during the renewal period, was part of the Tax HH and was submitted to the Tax/Hub as part of the RRV batch process. See the MAGI Renewal Process Guide for further information. b. If the Tax/Hub does not verify income, move to the next step (VCI/TALX). 2. **VCI / TALX:** This is the second level of verification on the Income Verification Hierarchy. a. If used to verify income the Verification source should be entered as '*TALX file viewed'* in the Expert system. b. If there is no income information found or income is unable to verified through this interface, move to the next step (SEW). 3. **SEW (STATE EMPLOYER WAGE):** Income reported quarterly by the Department of Labor. a. Compare the attested income to the SEW reported wages (divide SEW by 3 to obtain a monthly total). See the SEW Compatibility Calculator for further information. If SEW is used to verify income, the "Verified by SEW" box must be checked in the Expert system when running the budget. b. If SEW is unable to verify income, move to the next step (Paper Verification). 4. **PAPER VERIFICATION (DOCUMENT IMAGING, EMPLOYER CONTACT & NARRATIVES):** Review Document Imaging for paystubs or Employer Verification, review recent narratives for employment information / verification, both EA and MEDICAID narratives. If unsuccessful, attempt to verify the employment by placing a call to the employer. 5. **VERIFICATION REQUEST (VR):** As a last resort, send a VR for all unverified income
10	**Income and deductions verified by IRS Tax/Hub:**	• **IRS Tax/Hub is a verification tool that is allowed for MAGI Initial Applications.** This should be used as the first source of income verification on ALL MAGI Initial Applications. See the Medicaid Income Handling Guide for further information.

	***Cont.* - Income and deductions verified by IRS Tax/Hub:**	○ **Earned Income:** Checkout the case to the expert system and enter the attested earned income leaving all entries "*unverified*". If income does not pass the Tax/Hub, move on and attempt to verify income via VCI/TALX. ○ **Self-Employment:** Enter the attested self-employment income under the "Other Income" module select "MED Self-Emp Gain" or "MED Self-Emp Loss" leaving "*unverified*". If income does not pass the Tax/Hub, attempt call to household to complete self-employment ledgers. If unsuccessful, send a VR for verification (e.g., ledgers, tax return, SE records). ○ **Unearned Income:** Enter the attested unearned income under the "Other Income" module in financial section as "MED Unearned" leaving "*unverified*". If unearned income does not pass the Tax/Hub, further verification is needed. View appropriate interfaces (BDE, IUC, CSE, etc.), document imaging, call to SSA, VA and narratives. If unable to verify the unearned income send a VR for verification. ▪ Examples of unearned income include alimony, retirement income, pensions, dividends, interest, unemployment income, etc. See the Income Handling Part II WINK-ed for additional information. ○ **Deductions:** When processing initial applications, attested deductions must also be entered. If attested income does not pass the Tax/Hub, change the verification source to "unverified" until the deduction is verified. ○ If deductions are left unverified the deduction will not pull into budgets. ○ For further information, including how to enter deductions, see the *Deductions* section of this guide. ○ **Old instances of income in expert or old open VRs:** see Reasonable Explanation in the Income Handling Part II. If prior income or VRs exist on the case determine if they still need to be addresses or can be closed. Reach out to your Lead/Supervisor for help, if needed. ○ **Minors and tax dependents with income:** All attested income should be entered into Expert, even for minors and adult tax dependents. NFOCUS will determine whether filing requirements are met and either include or exclude this income in budgets. The amount of income Medicaid allows minors and tax dependents to earn before including in budgets can change from year to year. Find current amount in the Appendix: 477-000-010. **Retroactive Medicaid and the IRS Tax/Hub:** when income passes the Tax/Hub use the same attested income / deductions to process retroactive months. If income does not pass the Tax/Hub for retro months proceed to the next verification source (VCI). See the Retroactive Medicaid Process for further information.

	***Cont.* - Income and deductions verified by IRS Tax/Hub:**	• **How to run attested income against the IRS Tax/Hub:** o After entering income and deductions run the budget, ▪ If the income **passes the IRS Tax/Hub** the budget will be marked with a '+' on the authorization screen. View each budget separately prior to authorizing by double clicking on the budget. If a budget has passed the IRS Tax/Hub the words "IRS Returned Income Would Have Passed" will display on the left side of the screen. No further verification of income or deductions are needed. ▪ If the attested income/deductions **do not pass the IRS Tax/Hub** a 'v' will appear on the authorization screen indicating further verification(s) are necessary. When income is not Hub verified proceed to the *Non-Hub Verified Income* section. o If budget is correct: ▪ Determine eligibility. ▪ View unit size and compare to tax household. ▪ Authorize budget. ▪ Create Notice of Action. ▪ If retro is requested, process Retro Medicaid. See the Retroactive Medicaid Process. ▪ Check Case in and Continue to the *Review Date* section of this guide. **NOTE:** Children are ineligible for CHIP if they are enrolled in other health insurance. *This does not apply to continuously eligible children.* • If children are determined eligible for CHIP and have current Federally Facilitated Marketplace (FFM) coverage, eligibility may be determined and coverage overlap while the individual's FFM insurance is terminated. If the household indicates they have insurance and no further information is provided, follow-up is needed to determine the type of insurance coverage (e.g., employer-sponsored coverage or FFM coverage) and if the policy is still current. This information is also found in the *TPL* section below.
11	**Non-Hub Verified Income:**	• **VCI / TALX –** If the income is not IRS Tax/Hub compatible attempt verification using VCI/TALX. Ping VCI/TALX for all HH members (14 years of age and older) currently listed as "In HH" that show up on the "Verify Current Income" screen. o If income is verified by VCI/TALX, enter paystubs in the Expert system based on the information retrieved by VCI and *Average/Convert* the income. o The Verifications source in Expert should be updated to '*TALX file viewed'*.

	Cont. **- Non-Hub Verified Income:**	▪ The pay schedule should contain the same pay frequency that is reported through VCI (e.g., if VCI shows a bi-weekly pay schedule, create a bi-weekly pay schedule in Expert). ▪ If income is verified by VCI/TALX, and retroactive Medicaid is requested, use Actual Only income from VCI/TALX in the retro months. See the Retroactive Medicaid Process. o When VCI returns income, it is usually considered verified except in the following instances: ▪ If VCI shows less than a month's worth of income. ▪ If VCI shows income that does not fit the pay schedule, a phone call to the individual may be necessary to clarify the income. o Some individuals may have more than one income, meaning SEW and DI may also need reviewed to discern if there are multiple sources of income. **TOOL:** Income Handling Part II o If VCI/TALX returns no results or income is unable to verified using this interface, proceed to the next level of income verification (SEW). • **SEW (STATE EMPLOYER WAGE) –** If the income is not Tax/Hub compatible and is unable to be verified through VCI/TALX, compare the attested income against the most recent SEW Quarter (divide SEW by 3 to obtain a monthly total). o If the attested income **is Reasonably Compatible** with the most recent SEW Quarter, enter the attested income and leave '*unverified*', run the budget using the *Pay Schedule* calculation and check the '**Verified by SEW'** box. For more information: See the SEW Compatibility Calculator or Income Handling WINK-ed Part I for further information ▪ If income is found to be SEW compatible, also use the attested pay schedule for determining eligibility for retro months. See the Retroactive Medicaid Process. o If income **is not Reasonably Compatible** with SEW, first attempt a call the individual to obtain an amended attestation of income to compare to SEW. If calling the individual does not result in income being reasonably compatible with SEW move to the next level income verification. o If SEW shows income not attested to on the application, look for collateral verification sources for this income (next section), if Collateral Verifications do not exist, call the individual to clarify and get attestation of this income. Reasonable Explanation can be used if the individual claims the income ended in a month prior to months where MED is requested. ▪ If SEW shows unreported/unattested income and the worker is unable to get ahold of the HH for an attestation, this should be treated as a lead only. Further verification (e.g., VR) would be required prior to utilizing the income in the budget.

	***Cont.* - Non-Hub Verified Income:**	• **PAPER/COLLATERAL VERIFICATION –** If electronic interfaces (Tax/Hub, VCI/TALX and SEW) are unable to verify income the next level of verification is Paper/Collateral Verification. o This can include verification/documentation found in document imaging, narratives (both MLTC and EA), recent applications submitted (both MLTC and EA) and employer contact (Telephonic employer income verification or TEIV). o Steps for utilizing previous collateral verification: ▪ Check Document imaging for paystubs or other employment verification. ▪ Check recent prior narratives for both Medicaid and Economic Assistance. Narratives can also contain the individual's attested end date for employment. ▪ Check recent applications submitted to both MLTC and EA. ▪ Call employer directly. o **Missing Paystubs:** If the individual provided paystubs that are consecutive, however missing a paystub between the paystubs provided, use the Missing Paystub Year-to-Date Calculator to determine the gross amount of the missing paystub instead of sending a VR. o **Self-employment:** If attested SE income did not pass the Tax/Hub, paper verification is needed. First attempt to obtain ledgers via phone call to the individual. If unable to reach the individual send a VR requesting verification of self-employment income, ledgers or their most recent tax returns, including all schedules. ▪ For additional information, see the Self-Employment WINK-ed. ▪ See the MAGI and Non-MAGI – SE Calculator to figure income based on ledgers. ▪ For more information on how to handle self-employment involving S-corp/partnerships, see MAGI Partnership and S-corp Income. • **VERIFICATION REQUESTS (VRs) –** If unable to verify income through electronic data sources and paper/collateral forms of verification, send a Verification Request (VR.) Every effort should be made to verify income before sending a VR.
12	**Retroactive Medicaid Process:**	• Review the application for any retroactive Medicaid requests. • Do not pend a retro program case until an eligibility determination can be made (eligible or ineligible). • Any Authorized/Case Representative will need to be added to the separate Retro MED Program Case. • Detailed information and procedures on Retroactive Medicaid can be found in the Retroactive Medicaid Process Guide.

13	**Deductions:**	• Allowable MAGI Deductions are found in the Appendix NAC 477-000-008. Additional examples, maximum amounts allowed and how to verify are in the MAGI Deduction Guide. o Some payroll Deductions are always considered Pre-Tax Deductions and, if listed on a paystub, are allowable. These include Health Savings Accounts (HSA) and Accident or Health Plan (Medical, Dental, Vision). • Initial determinations should be made without waiting for verification of the deduction(s) **IF** the HH is eligible without using the deduction(s). Add a comment to the Notice of Action to inform the applicant they have the option to provide additional verifications in order for the deduction(s) to be used in eligibility determinations. • **Calculating MAGI Deductions:** o The computation of deductions are handled in the same manner as the computation of income. ▪ Deductions which vary must be averaged / converted. ▪ If using 30 or 90 day average for income, use the same 30 or 90 day average to compute deductions. (example: 401K deductions are determined by a percentage of income.) ▪ **Retroactive Deductions:** 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 paystubs without converting them to a monthly amount. o **Entering deductions when income is verified by IRS Tax/Hub:** When processing initial applications, attested deductions must be entered and combined into one entry: ▪ Specify the type of deduction in the "description" field. ▪ The verification source for the attested deduction should be "*Client Statement*." o **Entering deductions when income is not verified by IRS Tax/Hub:** When VCI/TALX, SEW or Paper Documentation is used to verify income, each deduction should be entered separately. ▪ Each verified deduction type should be entered under the "Expense" module in expert under "MAGI Expenses" from the drop-down menu, choose option "other deductions." ▪ The deduction must be verified using the appropriate verification source. Remember, the computation of deductions is handled in the same manner as the computation of income. ▪ When deductions are verified with tax documents, configure an annualized deduction schedule verified by tax returns.

14	**Minimum Essential Coverage (MEC):**	• Review the application to determine if there is qualified health coverage for all of the children OR they will be eligible for Medicaid when the budget is processed. **Attestation of MEC for a dependent child is acceptable unless there is questionable information.** See MEC vs Creditable Coverage**.** o **Yes:** If all the children are covered by MEC or will be eligible for Medicaid, the P/CR will be eligible to be considered for MAGI Expansion. o **No:** If any of the children are not covered by MEC or eligible for Medicaid, the parent will **not** be considered for MAGI Expansion eligibility.
15	**Third Party Liability (TPL):**	• Check to see if any applicants are covered by TPL. If applicants with TPL are approved, policy information **MUST** be entered into C1.See the TPL Process Guide and C1 TPL Quick Reference Guide for further information. o Application should be reviewed to determine if the household has provided adequate TPL information to add insurance to C1. Review Document Imaging (DI) for copies of the card which may have already been provided. C1 may be reviewed to determine if policy was already entered. o If information is not available, attempt call to the individual to obtain the needed information. A call-out to the TPL provider may also be appropriate if you are attempting to verify minimal information, such as: start date/end date, who is covered, etc. o As a last resort, send a VR requesting a copy of the insurance card. ▪ **Do not delay processing of the case if the insurance card or other policy information is all that is needed. Process the case and then send a VR requesting TPL verification.** ▪ If the VR for TPL information is not received, any active adults in the case covered by the TPL should be closed for "*Failed to Provide Information*". Children are not affected by FTP TPL information and must remain open. • **CHIP Eligibility**: Children are ineligible for CHIP if they are enrolled in other creditable health insurance (TPL). *This does not apply to continuously eligible children.* o However, if children are determined eligible for CHIP, and have current Federally Facilitated Marketplace (FFM) coverage, eligibility **may** be determined and coverage overlap while the individual's FFM insurance is terminated. Once approved for Medicaid, an account transfer is sent to the Marketplace to inform them of the eligibility decision. o If the household indicates they have insurance and no further information is provided, follow-up is needed to determine the type of insurance coverage (e.g., employer-sponsored coverage or FFM coverage) and if this is still a current policy prior to processing children into CHIP.

16	**Process and Review Budgets:**	• When all information is available to run the budget, update NFOCUS and process for eligibility. o Start running budgets from the application month forward through the come up month. When running budgets, the come-up month must be processed. NFOCUS will take the worker through the needed budgets as long as the worker does not cancel out. ▪ The worker must run the current and come-up month budgets anytime configurations is changed. ▪ If a budget is run after cutoff, the next two months must be run. o If Retro months are requested, and information is available to process, run budgets for retro months prior to application month. o Review all budgets for correctness. o If budget is correct: ▪ Determine eligibility. ▪ View unit size and compare to tax household. ▪ Authorize budget. o If budget is incorrect: ▪ Make corrections as needed. ▪ Determine eligibility. ▪ View unit size and compare to tax household authorize budget. • Assure that Program Case name remains FR Adult, if applicable. This will assure that notice is generated to the adult, online AccessNebraska account is available and Heritage Health Enrollment and MCO information is accessible to the FR Adult.
17	**Continuous Eligibility:**	• Review for any approved individuals who may be continuously eligible. CE individuals include: o Children, pregnant individuals or individuals in their postpartum period, deemed newborns (newborns born to a Medicaid active mother) and 599 CHIP newborns. o **Best Practice:** Narrate under the *Continuous Eligibility* subheading about who is CE and the timeframe of their CE period. o See the Continuous Eligibility Guide for more information.
18	**Review Date:**	• Review date should be set so that the review occurs 12 months from application month. o For example, if an application dated 4/16/2020 is approved, the review should be set for 3/31/2021.

19	**Notices:**	• Generate and Send Notice of Action. Review this once the case is checked in to assure that appropriate information is displayed on the notice. May need to update comments with specific information that may not be captured. o If notice is generated for "*Failed to Provide Information"*, staff may communicate missing information.
20	**Check Case In:**	• Check for accuracy of notice and comments on notice after case is checked in.
21	**Potential Income:**	• Per Medicaid policy, an individual who is receiving Medicaid is required to apply for potential income they may be entitled to within 60 days. o *Potential income may include the following*: unemployment compensation, annuities, pensions, retirement, and disability benefits to which they are entitled. Use critical thinking to determine if the individual may be eligible for this income. • If determined the individual might be eligible for this income, send a VR to the individual, allowing 60 days for the individual to provide verification that he/she has taken all necessary steps to obtain this income. Update the VR due date to 60 days from the date the VR is created.
22	**CHARTS Referral:**	• After processing, determine if a Referral to CSE (CHARTS Referral) needs to be made. See the Child Support Referral Guide for further information on submitting a CHARTS referral.
23	**Voter Registration:**	• Check the application to determine if the individual requested to apply to register to vote. See the Voter Registration SOP for further information. • If the individual requested to register to vote offer link to register on-line: o https://www.nebraska.gov/apps-sos-voter-registration/ or provide Voter Registration form. A printable PDF version: https://sos.nebraska.gov/elec/pdf/vr-fillable.pdf
24	**Narrate:**	• Narrate actions taken on the case. o If case is approved, narrate through the Approval subject and subheadings. o If case is denied for "*Failed to Provide Information"*, indicate missing information and Day 90 from the application date. o If the case remains pending past the required timeframes for an eligibility determination, the worker must review the case and document in the narrative the reason a decision is unable to be made.
25	**Clear Alerts/Work Tasks**	• Process and clear any MLTC alerts or work tasks on the case.
26	**Case Mode:**	• Check for correct case mode: o Case should be in "Change Management" mode if processing is complete. o Case should be in "Processing" mode if denied for "*Failed to Provide Information"*.

27	**Information Provided Within 90 Days of Application on Denied Case:** 90 Day Redetermination Examples	• Determine if it is within the 90 days from the application date. If within 90 days and: o All information / verifications are present – re-pend back to application month and process same day. o If still unable to process, do not re-pend the case. Send speed note stating what information / verifications are still needed. o See Changes Reported During the 90 Day Redetermination Period for further information on the process to take when a new change is reported during the 90 day redetermination period.
PROCESS COMPLETE		

Non-MAGI Eligibility Processing – New Application

1	**Begin:**	• Retrieve and accept the work task "Application Received" as applicable.
2	**Check for Valid Application:**	• Check for a valid application: containing name, address and signature. (see **477 NAC 3-005**). o If application is valid, go to *Step 3* in this section. o If application is not valid, take appropriate steps to obtain a valid application. ▪ See the Stand Alone Application Chart for information on proper applications. ▪ See Valid Application Signature for information on valid application signatures. ▪ Utilize the MLTC Consent Line Process Guide for applications missing a signature. o Attempt to contact individual by phone for follow-up if areas on the application are left blank or where clarification is needed. See Unanswered Questions for further information. • Refer to the Former Foster Care Guide for further information when the application indicates that someone was previously in Foster Care, in **any** state, and is under age 26. • **Incarcerated Individuals -** Applications ***must*** be accepted and Medicaid eligibility determined for individuals who are residing in a 24 hour facility that are being discharged either the month the application was submitted or the month after the application was submitted. *Examples of these facilities include* Youth Rehabilitation and Treatment Centers, Regional Centers, Department of Corrections facilities, County Jails, and County Youth facilities. *IMPORTANT NOTE:* The SUPPORT Act of October 2018 added a provision that applies to applications received for juveniles (defined as individuals under age 21 and individuals who may be eligible under Former Foster Care). The state is required to accept and process applications for individuals up to age 26 at any point during their period of incarceration. o **Universal Staff Duties -** For any application received where an individual indicates they are incarcerated, staff must assign the case to the **INC ASSIST** position number (66118075). See Medicaid Position Numbers for Case Assignments for further information. o **Assigned Staff Duties** – Verification of the release date from the facility is required prior to processing the application. Verifications can be provided from staff at the facility. The assigned worker will also need to know where the individual will be residing upon discharge, household composition, tax household information, and verification of income of any individual who would be financially responsible for the client based on the tax filing status.

	***Cont.* - Check for Valid Application:**	• **Social Security Low Income Subsidy (LIS) SSA-L Applications:** The Social Security Administration electronically transmits the data from their application for extra help with Medicare Part D prescription drug plan costs to Nebraska for those individuals who have filed the SSA application and have a Nebraska mailing address. ◦ This information is to be considered an application for Medicaid for a specific individual and his or her spouse, if applicable. SSA automatically sends the information to Nebraska unless the applicant specifically indicated on the application that the information should not be sent. o The SSA LIS application **does not include** the following on the application because SSA does not capture this information on their application. This information will need to be gathered and verified by the worker: ▪ US Citizen or Lawful Immigrant status and Alien Number ▪ Living arrangement ▪ Shelter/Utility expenses ▪ Third Party Liability health insurance information ▪ Names of HH members other than spouses ▪ Burial fund information ▪ Life Insurance information ▪ VA claim number o The SSA LIS application **does include**: ▪ **App Request Date** – Date applicant filed SSA LIS application, to be used as start date for Medicaid benefits. ▪ **App Received Date** – Date the SSA transferred the app to DHHS. ▪ **SSA Subsidy Approval** - Result of SSA LIS determination Yes=Award No=Denial ▪ **SSA LIS Approval/Disapproval Date** - Date SSA made determination of LIS eligibility. ▪ **Subsidy Effective Date** – Effective date of approved subsidy app. If the applicant already has Medicare, this will be the first month of eligibility for extra help with Medicare Part D expenses. ▪ **Subsidy Denial Reason** – The reason SSA denied the LIS application. Applicant may have more than one denial reason. • **Not an A/B Medicare Beneficiary** – The applicant wasn't receiving Medicare Part A or B benefits during the LIS process. • **Failure to Cooperate** – The applicant did not provide the necessary information requested by SSA to determine LIS eligibility. • **Resources** – The applicant's countable resources exceed LIS guidelines.

	***Cont.* - Check for Valid Application:**	• **Income** - The applicant's countable income exceeds LIS guidelines. ▪ **Applicant Name, Gender, DOB & SSN** ▪ **SSA/RRB Claim Number** - Claim number the applicant's Medicare/Social Security or Railroad Retirement Board benefit records are filed under. • SSA does not provide the claim number for Veteran's benefits. • Do not enter the claim number shown in the Expert System Medicare task if the applicant is receiving Railroad Retirement benefits. The number sent from SSA for Railroad beneficiaries is a converted number and is not accurate. You will need to obtain the Medicare claim number from the Railroad beneficiary.
3	**Compare Application to System:**	• Review NFOCUS entries with information provided on current application (see also the Non-MAGI Initial Processing Checklist). If information does not match, make corrections to the information in NFOCUS: o Screen for Duplicate Application (see below). o Screen to determine if the application is considered a renewal form (e.g., case was previously closed less than 90 days ago during the review process for not providing a renewal form). See 90 Day Redetermination Examples for further information. o Voter registration requested. o Comments section. o Address (physical and mailing), telephone and email information. o Notification preferences: mail, email, text (SMS). o Correct applicants pended? o Screen to ensure application is a Non-MAGI application and review for age and/or disability. o Add Authorized Representative, if listed. o Review for Retroactive Medicaid request. If requested follow the steps in the Retroactive Medicaid Process document. o Review Sanctions. o Review Work Tasks and Alerts. • **Duplicate Applications** – o An application that is: 1. received on an active case participant with no review due; or, 2. received within 90 days of the closure or denial date is considered a duplicate application. o Duplicate applications received must be reviewed for changes and action taken on these reported changes. See Duplicate Applications and "Is a New Medicaid Application Needed?" for further information.

	***Cont.* - Compare Application to System:**	○ **Once an application has been identified as a duplicate, the following steps must be taken:** 1. If the case was pended, deny the pending case for 'Other' and send a notice. 2. If the case was not pended, a Generic Notice must be created. 3. Include comments on the Notice: • Manual reference **477 NAC 3-005.06** • Explanation that the application is being denied as it was identified as duplicate. • Inform the applicant of verification(s) needed to complete determination and the deadline for the 90 days, calculated from the date of the original application. ○ **TOOL:** Calculator for Days 30, 45, 60, and 90. 4. Check Program Case Mode: it may be necessary to update it to Change Management. 5. Change the application tie reason from initial to duplicate. • From the detail master case window, select the program applications. • Highlight the duplicate application window and select update. • Change the application reason from initial to duplicate. • **Active Individuals** – If an individual is active in a Medicaid program case and would be transitioning to a different Medicaid category a new application is not required. Application forms can be used as a tool for staff to obtain information from an individual however, it **cannot** be a required form that the agency obtains from an active individual **unless it is at the applicable renewal time**. ***Example**:* An individual is in MAGI Expansion and begins receiving Medicare. The individual needs to be reviewed for eligibility in a Non-MAGI category. A new application cannot be required.
4	**Social Security Number (SSN):**	• Check applicant's blue SSA interface to ensure they have HUB SSN Verified. ○ If not verified, first check demographic information (name, DOB and SSN) has been entered correctly in NFOCUS. ○ If further clarification is needed after comparing with the application, call the individual. ○ If call to individual does not resolve the issue, send a VR. Do not request copies of Social Security cards for individuals. • Medicaid recipients must have a valid Social Security Number except for the following: ○ Infants less than a year old who were born to a Medicaid eligible mother. ○ 599 CHIP & EMSA participants. ○ Applicants with a "Well Established Religious Objection". ○ Individuals who are not eligible to receive a SSN. ○ Individuals who do not have a SSN and may only be issues a SSN for a valid non-work reason. ○ An individual that is not requesting Medicaid is not required to provide their SSN.

	***Cont.* - Social Security Number (SSN):**	• For individuals who **DO NOT CURRENTLY** have a Social Security Number and the SSN is the only item needed to process – continue processing the application including submitting to AVS for resource verification, if possible. If approved, create a Verification Request informing the individual they have 90 days from date of application to provide a SSN or verification that they have applied for a Social Security Number with the SSA. The VR due date must be set for 90 days from the date the VR is being sent.
5	**Citizenship & Immigration:**	• Check that all applicants either have verified U.S. citizenship or verified eligible immigration status. If citizenship or immigration status has not been verified, submit all applicants for verification: o The Citizenship and Immigration screen (*Actions* menu > US Citizenship and Immigration) and the blue SSA interface can be reviewed for citizenship verification. o The VLP interface can be reviewed for eligible immigration status. • **Reasonable Opportunity (RO) Period:** If the applicant attests to being a US citizen or having a Medicaid eligible immigration status that cannot be verified because there are no available electronic data sources, VLP is in Step 2 or 3, or paper verifications are being requested; process the application as long as all other points of eligibility have been verified. o If additional information is needed from the applicant to verify citizenship or immigration status (e.g., copies of documents), send a VR for the information to be returned. The VR due date must mirror the time allowed for the reasonable opportunity period. o Staff **must** set a manual 95 day alert for the individual's ongoing eligibility to be reviewed. ▪ RO policy allows for the 90 day clock to start on the date the individual receives the notice (generally 5 days after the date of notice). o On the approval notice, notify the applicant of the reasonable opportunity period using the language below. If an approval notice is not generated, send a Generic Notice with comments about the 90 day reasonable opportunity period, using the notice wording below. A notice is required to ensure the individual receives rights and responsibilities. **Notice Wording:** *Citizenship or non-citizen status has not been verified for (NAME). A 90-day reasonable opportunity period (**477 NAC 5-006**) has been applied for the Department to conclude the electronic verification process and/or the applicant to provide the satisfactory citizenship or immigration documents. Retroactive Medicaid cannot be authorized during the reasonable opportunity period (42 CFR 435.956(a)(5)(iii)). If citizenship or non-citizen status has not been verified by (DATE; use the calculator on MERL), Medicaid benefits will be terminated.* o See Reasonable Opportunity Period and Reasonable Opportunity Examples for more information.

	***Cont.* - Citizenship & Immigration:**	• **Refugees:** Individuals identified as refugees who have been in the country for **12 months or less** should be assigned to the Refugee Medicaid Referral position number (87055714). See the Refugee Process for more information.
		  ○ If processing a refugee individual who has been in the country for **more than 12 months**, review the Citizenship/Immigration task in the Expert system. If Refugee Resettlement Program (RRP) is listed, this is not a valid Medicaid immigration status and must be updated to the current immigration status or REF207 before processing any budgets.
		• **EMSA:** If no immigration status is indicated, consider eligibility for Emergency Medical Services Assistance (EMSA). See the EMSA Process Guide for further information.
		• For any situation where SAVE was utilized to verify immigration status, the SAVE documents must be uploaded to Document Imaging (DI).
		• **Process Guides and Tools:**
		  ○ MLTC Citizenship and Immigration Guide
		  ○ Qualified Non-Citizen Status Eligibility
		  ○ How to submit G845: G-845 Immigration Documentation Process

6	**Follow the Nebraska Verification Plan:**	• Compare application information with Hub verification results. Attempt to contact the individual by phone for follow-up if areas on the application are left blank or further clarification is needed. See Unanswered Questions
		• Review application for:
		  ○ Residency
		  ○ Tribal membership
		  ○ Family relationship(s)
		  ○ **Income** (Unless individual has an SSI determination of eligibility):
		  ▪ Electronic data sources (e.g., VCI/TALX, SEW) and callouts, shall be utilized to verify income if available. If the electronic data sources are not available, reasonably compatible or a reasonable explanation does not apply and call outs are not successful, paper documentation will be required (e.g., paystubs, employer form, etc.).
		  ▪ See the Medicaid Income Handling Guide for further information on verification of income. **For Non-MAGI, the IRS Tax/Hub is not utilized.**
		  ○ **Resources** (Unless individual has an SSI determination of eligibility):
		  ▪ Follow the electronic AVS verification process:

	***Cont.* - Follow the Nebraska Verification Plan:**	• Check for AVS consent (applicant and/or non-applicant spouse) and update the AVS Consent window. See Using the AVS Consent Window in NFOCUS for further information. o If there is no consent, obtain consent as required and update the AVS Consent window. The MLTC Consent Line can be used to obtain AVS consent over phone • Refer to AVS Procedural Guide for instructions on AVS and steps for AVS submission. o Staff must wait the full AVS timeframe prior to requiring paper documentation from the HH. See the Expedited AVS Process for exceptions to waiting the full AVS timeframe. o Staff must submit a direct request, if necessary (*Section 5* of AVS Guide) o Once information is received, enter the AVS results in the Expert system. o After a decision has been made in NFOCUS regarding Medicaid eligibility, action must be taken to update the results in AVS. (*Section 10* of AVS Guide). ▪ Send Verification Request (VR) to applicant for resource types that will not be verified by AVS and any other required verifications (e.g., earned income). See the Resource Verification Plan and the Resource Verification WINK-ed for further information. **NOTE:** If it appears that a member of the case may qualify for potential income, send a VR requiring the individual to apply for the potential benefit within 60 days of the date of the VR. Update the VR due date to 60 days from the date the VR is created.
7	**Disability Determination:**	• Review for eligibility in the appropriate Medicaid category. See ABD or HHA Process Flow for further information. • If applicant is ineligible in a MAGI category and: o Has a current disability, move forward with a Non-MAGI determination. o Has filed an application with SSA and are pending a disability with no determination made, see the Position Numbers for Case Assignments document. o Has applied for SSI and they have been denied, review the SRT Guide for possible referral. If an SRT referral is not appropriate, deny the case for failure to meet an eligibility category even if they have appealed with Social Security. If they subsequently win their appeal then we will approve Medicaid retroactive to that date. See the SRT Guide for additional information on notice requirements and a possible referral to SDP. o If applicant has won a disability appeal decision, check for Medicaid applications that have been filed back to the original disability date. Change the application received date to the oldest possible date.

8	**Retroactive Medicaid Process:**	• Review the application for any retroactive Medicaid requests. • Do not pend a retro program case until an eligibility determination can be made (eligible or ineligible). • Any Authorized Representatives need to be added to the separate Retro Program Case. • Detailed information and procedures on the Retroactive Medicaid process can be found in the Retroactive Medicaid Process Guide.
9	**Living Arrangement:**	• All living arrangements are eligible to be processed as MAGI and Non-MAGI. • See the ABD or HHA Process Flow and the Living Arrangement Guide for further information. • **Incarcerated Individuals -** Applications ***must*** be accepted and Medicaid eligibility determined for individuals who are residing in a 24 hour facility that are being discharged either the month the application was submitted or the month after the application was submitted. *Examples of these facilities include* Youth Rehabilitation and Treatment Centers, Regional Centers, Department of Corrections facilities, County Jails, and County Youth facilities. *IMPORTANT NOTE:* The SUPPORT Act of October 2018 added a provision that applies to applications received for juveniles (defined as individuals under age 21 and individuals who may be eligible under Former Foster Care). The state is required to accept and process applications for individuals up to age 26 at any point during their period of incarceration. o **Universal Staff Duties -** For any application received where an individual indicates they are incarcerated, staff must assign the case to the **INC ASSIST** position number (66118075). See Medicaid Position Numbers for Case Assignments for further information. o **Assigned Staff Duties** – Verification of the release date from the facility is required prior to processing the application. Verifications can be provided from staff at the facility. The assigned worker will also need to know where the individual will be residing upon discharge, household composition, tax household information, and verification of income of any individual who would be financially responsible for the client based on the tax filing status.
10	**Third Party Liability (TPL)/Deductions:**	• Check to see if any applicants are covered by TPL. See the TPL Process Guide, Guide, and WINK – Understanding the Parts of Medicare for further information. o If applicants with TPL are approved, policy information **must** be entered into C1. ▪ Application should be reviewed to determine if the household has provided adequate TPL information to add insurance to C1. Review Document Imaging (DI) for copies of the card which may have already been provided. C1 may be reviewed to determine if policy was already entered.

	***Cont.* - Third Party Liability (TPL)/Deductions:**	▪ If information is not available, attempt a call to the individual to obtain the needed information. A call-out to the TPL provider may also be appropriate if you are attempting to verify minimal information, such as: start date/end date, who is covered, etc. o As a last resort, send a VR requesting a copy of the insurance card. ▪ **Do not delay processing of the case if the insurance card or other policy information is all that is needed. Process the case and then send a VR requesting TPL verification.** If the VR for TPL information is not received, any active adults in the case covered by the TPL should be closed for "*Failed to Provide Information*". Children are not affected by FTP TPL information and must remain open.
11	**Process and Review Budget:**	• Prior to processing the budget: o Refer to the AVS Procedural Guide. o The AVS processing time (10 days) should be completed prior to a determination. If an exception is met, see Expedited AVS Process Reasons for further information. o Enter the AVS results in the Expert system. • When all information is available to run the budget, start running the budgets from the application month forward through the come up month. Review budget for correctness. o When running budgets, the come-up month must be processed. NFOCUS will take the worker through the needed budgets as long as the worker does not cancel out. o The worker must run the current and come-up month budgets anytime configuration is changed. o If a budget is run after cutoff, the next two months must be run. • If budget is correct: o Authorize budget. o Determine eligibility if budget is incorrect. o Make corrections as needed. o Authorize budget. o Determine eligibility.
12	**Notices:**	• Generate and Send Notice of Action. Review once the case is checked in to assure that appropriate information is displayed on the notice. May need to update comments with specific information that may not be captured. o If notice is generated for "*Failed to Provide Information"*, staff may communicate missing information.
13	**CHARTS Referral:**	• After processing, determine if a Referral to CSE (CHARTS Referral) needs to be made. See the Child Support Referral Guide for further information on submitting a CHARTS referral.

14	**Voter Registration:**	• Check the application to determine if the individual requested to apply to register to vote. See the Voter Registration SOP for further information. • If the individual requested to register to vote offer link to register on-line: o https://www.nebraska.gov/apps-sos-voter-registration/ or provide Voter Registration form. A printable PDF version: https://sos.nebraska.gov/elec/pdf/vr-fillable.pdf
15	**Narrate:**	• Narrate – include information that explains the actions taken in a way that others can follow the work completed on the case. o If case is approved, narrate through the Approval subject and subheadings. o If case is denied for "*Failed to Provide Information"*, indicate missing information and day 90 from the application date. o If case remains pending past the required timeframes for an eligibility determination, the worker must review the case and document in the narrative the reason a decision is unable to be made.
16	**Case Mode:**	• Check mode to see if case is in correct mode. o Processing mode will remain if denied for "*Failed to Provide Information"*. o If case was in Assigned mode when denied for FTP, manually change the mode to Processing. o If case was in Assigned mode when denied for reasons other than FTP, manually change the Mode to Change Management. o If denied for any other reason the system will change the mode to Change Management.
17	**Information Provided Within 90 Days of Application on Denied Case:** 90 Day Redetermination Examples	• Determine if it is within the 90 days from the application date. If within 90 days and: o All information / verifications are present - re-pend and process the same day. o If still unable to process, do not re-pend the case. Send speed note stating what information / verifications are still needed. o See Changes Reported During the 90 Day Redetermination Period for further information on the process to take when a new change is reported during the 90 day redetermination period.
PROCESS COMPLETE		

The following sections from the MLTC Processing Guide have been moved to the Non-MAGI & Combined Renewal Process Guide:

- ***Non-MAGI Renewal (Non-SSI);***
- ***Non-MAGI Renewal SSI*/1619(b); and,**
- **The renewal steps of the *Spousal Impoverishment Case – ASSIGNED* section below.**

Spousal Impoverishment Case – ASSIGNED

1	**Begin:**	• Identify case as being a Spousal Impoverishment (SIMP) case. Determine the individual's specified living arrangement. • If you will not be the assigned worker, transfer to the appropriate position number. See Medicaid Position Numbers for Case Assignments. o The process for the worker not assigned to the Spousal Impoverishment cases is completed. • If you will be the assigned worker for the Spousal Impoverishment Case, continue to step 2.
2	**Assign Case:**	• Ensure all of the Medicaid program cases are assigned. • If there is no Assessment of Resources (IM-73) continue to step 3. • If there is an Assessment of Resources (IM-73), but no Designation of Resources (IM-74), continue to step 7. • If both the Assessment and Designation have previously been completed for this individual, continue processing the SIMP case.
3	**Determine Month for the Assessment of Resources:**	• Determine the month the spouse in the specified living arrangement began a stay of 30 consecutive days in a specified living arrangement.
4	**Contact the Individual or Case Representative:**	• Explain the purpose of Spousal Impoverishment and the Assessment and Designation Process. Gather resource declarations for the month the IM-73 will need to be completed. • If there is a valid application, submit an AVS request for the applicant and spouse. If the month of assessment will not be verified in the 60 month look back, phone/paper verification of accounts will be required. • If this is a request for an assessment only, do not use AVS to verify accounts. Phone/paper verification of all resource types will be required. • Request proof of other Resource type values for the month needed for the IM-73.
5	**Review Verifications and Prepare the IM-73:**	• Review Resource verifications as they are received, considering if verifications are complete or if additional verification is needed. • When Resource verification is completed prepare the IM-73 to be signed. • Advise the couple of the resource limits, allowable reductions of resources, and future steps.

6	**Complete IM-73:**	• Obtain all signatures on the IM-73 and receive the completed IM-73. • If the couple's resources exceed the allowable amounts for the community spouse and the individual, they may need to wait to apply for Medicaid, or if application has been filed, deny the application. Change the Medicaid Program Case to Change Management. The process is complete. • When budgeting, follow the Medicaid Resource Verification Plan and the Resource Verification WINK-ed. • If the couple's resources are within guidelines, case remains assigned. Continue to *Step 7* in this section.
7	**Determine if Application is Needed or Received and Complete IM-74:**	• Check to see if an application is needed. If so, send VR to request an application be filed. If application has not been received when VR is due, change the Medicaid Program Case to Change Management. The process is complete. • If we have a valid application, check that the Community Spouse has been added so interfaces will be received. • When Resources are verified within permitted limits, contact the individual or case representative to explain the Designation of Resource process and determine how the couple wants to designate the Resources. Complete the IM-74 and obtain all signatures.
8	**Receive Signed IM-74:**	• Receive signed IM-74. Process the case, entering resources as indicated on the IM-74, and using SIMP budgeting. o Follow the steps in the SIMP Budgeting Q&A and the Tip of the Week: Spousal Impoverishment (SIMP) Interspousal Transfers.
9	**Renewal of SIMP case:**	• Follow the steps in the Non-MAGI & Combined Renewal Process Guide. Additionally, verify the following information: o Verify the living arrangement of the individual and community spouse. o Verify Income of community spouse and/or family members included in the calculation of the SIMP budget. If verified income equals or exceeds the maintenance need standard, additional income verification is not needed. o Verify shelter and utility costs for community spouse and/or family members. o Verify health insurance premiums and who is covered for all family members. o Verify the Resources of the individual per the AVS Procedural Guide and the Medicaid Resource Verification Plan and the Resource Verification WINK-ed. ▪ Compare the participant's current resources to the IM-74 and determine if additional verification of interspousal transfers is required. If the Medicaid spouse transferred assets to the community spouse, ensure the community spouse remained at or below their reserved amount at the time of the transfer. Process SIMP Budget. See Tip of the Week: Spousal Impoverishment (SIMP) Interspousal Transfers.

10	**Notices:**	• Generate and Send Notice of Action to individual(s). o If completing a renewal and the individual remains eligible, ensure the Medicaid Renewal Notice Language is included on the notice. o If a notice is generated for "*Failed to Provide Information"*, staff may communicate missing information.
11	**Information Provided Within 90 Days of Application on Denied Case:** 90 Day Redetermination Examples	• Determine if it is within the 90 days from the application date. If within 90 days and: o All information / verifications are present – re-pend and process the same day. o If still unable to process, do not re-pend the case. Send speed note stating what information / verifications are still needed. o See Changes Reported During the 90 Day Redetermination Period for further information on the process to take when a new change is reported during the 90 day redetermination period.
PROCESS COMPLETE		

Disability Application

(Application Attests to Disability – No Determination)

1	**Begin:**	• Retrieve and accept the work task "Application Received". • Application pended in Non-MAGI queue.
2	**Check Application for Completeness:**	• Check for a valid application: containing name, address and signature (see **477 NAC 3-005**). o Types of Applications that can be utilized for determining Non-MAGI eligibility (see the Stand Alone Application Chart for information on valid applications). ▪ MILTC-64 application. (**NO** supplemental application needed); or, • This is a standalone application for AABD/Medicaid. • Can be completed for applicants under age 65 who are disabled or applying for a disability determination; or an applicant over age 65. • Can only be used for families in which all members are elderly and/or disabled. ▪ Online or Phone application - HCNE/HCPH (**NO** supplemental needed); or, ▪ Federal online application – HCMP **AND** the supplemental application (MILTC-63); or, ▪ MILTC-53 **AND** the supplemental application (MILTC-63) • Confirm applicant age between 18 and 65 (AABD Disability begins at age 18 and ends the month of age 65). If individual is age 18, need to see if MAGI eligible while Disability is pending. • If application is valid, go to *Step 3* in this section. • If application is not valid, take appropriate steps to obtain a valid application. o See Valid Application Signature for information on valid application signatures. o Utilize the MLTC Consent Line Process Guide for applications missing a signature. o Attempt to contact individual by phone for follow-up if areas on the application are left blank or where clarification is needed. See Unanswered Questions for further information. • **Incarcerated Individuals -** Applications ***must*** be accepted and Medicaid eligibility determined for individuals who are residing in a 24 hour facility that are being discharged either the month the application was submitted or the month after the application was submitted. *Examples of these facilities include* Youth Rehabilitation and Treatment Centers, Regional Centers, Department of Corrections facilities, County Jails, and County Youth facilities.

	***Cont.* - Check Application for Completeness:**	*IMPORTANT NOTE:* The SUPPORT Act of October 2018 added a provision that applies to applications received for juveniles (defined as individuals under age 21 and individuals who may be eligible under Former Foster Care). The state is required to accept and process applications for individuals up to age 26 at any point during their period of incarceration. o **Universal Staff Duties -** For any application received where an individual indicates they are incarcerated, staff must assign the case to the **INC ASSIST** position number (66118075). See Medicaid Position Numbers for Case Assignments for further information. o **Assigned Staff Duties** – Verification of the release date from the facility is required prior to processing the application. Verifications can be provided from staff at the facility. The assigned worker will also need to know where the individual will be residing upon discharge, household composition, tax household information, and verification of income of any individual who would be financially responsible for the client based on the tax filing status.
3	**Disability Determination:**	• Review electronic interfaces and data on file for disability determination. o Bendex/BDE (Social Security) o SDX (SSI) o Verification of disability in Document Imaging (DI). • Review for eligibility in the appropriate Medicaid category. See ABD or HHA Process Flow for further information. • If applicant is ineligible in a MAGI category and: o Has a current disability, move forward with a Non-MAGI determination. See *Step 5* in this section. o No disability has been determined, move to *Step 4* in this section. o Is **denied by SSI for severity:** ▪ Deny Medicaid case (even under appeal); and, ▪ Narrate if they win the appeal Medicaid will be retroactive to that date. o Is **denied by SSI for duration**: ▪ Consider for referral to Economic Assistance for State Disability Program; and, ▪ Narrate if they win the appeal Medicaid will be retroactive to that date. • If applicant has won a disability appeal decision, check for Medicaid applications that have been filed back to the original disability date. Change the application received date to the oldest possible date.

4	**Confirm SSA Application or SSA Status if no disability determination has been made:**	• Determine if the applicant has filed for disability.
		  ○ SDX match on pending application.
		  ○ Or have verification of RSDI application made.
		• Review for situations where you would consider MAGI Expansion eligibility or go directly to the State Review Team without waiting for disability determination. Refer to ABD or HHA Process Flow and the SRT Process Guide for further information.
		• For applicants who are not appropriate for either SRT or SDP, and have no disability application pending:
		  ○ Deny the applicant using the reason "*Eligibility Requirements Not Met*".
		  ○ In the comment section of the notice, inform the applicant that eligibility for disability is made through Social Security. Ask the individual to make application with Social Security and then re-apply for Medicaid at that time.
		• Once it is determined the applicant **has filed and is pending determinations:**
		  ○ Place into position number: 27906498. See Medicaid Position Numbers for Case Assignments for further information.

5	**Process the Budget:**	• When notified of approval (alert) from interfaces, take the following steps:
		  ○ If **applicant is found eligible for SSI** (SDX interface - resources and income have already been checked and processed), open the Medicaid case from that pending month.
		  ○ If **applicant is receiving SSA disability** (BDE interface):
		  ▪ Verify resources and income.
		  ▪ Process the budget.

6	**Clear Alerts/Work Tasks:**	• Process and clear any alerts and work tasks on the case.

7	**Notices:**	• Generate and Send Notice of Action to individual(s).
		  ○ If completing a renewal and the individual remains eligible, ensure the Medicaid Renewal Notice Language is included on the notice.
		  ○ If a notice is generated for "*Failed to Provide Information"*, staff may communicate missing information.

8	**Narrate:**	• Narrate – include information that explains the actions taken in a way that others can follow the work completed on the case.
PROCESS COMPLETE		

Share of Cost (SOC)

1	**Medical Need:**	• Evaluate for medical need that exceeds the Share of Cost. o Contact the individual and ask if they want to be considered for SOC. **NOTE:** AD waiver and certain DD wavier (DDAC, CDD, DDAD) cases are set to active Medicaid.
2	**Pend:**	• If the individual says yes for SOC, re-pend the applicant (or the case depending on if there are any Medicaid eligible household members). o Determine if a supplemental application is needed.
3	**Follow Verification Plan:**	• Refer to the AVS Procedural Guide and the Medicaid Resource Verification Plan and the Resource Verification WINK-ed. • Send Verification Request Form (VR) to applicant for other resource types if necessary.
4	**Determine Eligibility:**	• Update NFOCUS and determine eligibility. **NOTE:** If the participant has earnings from employment or self-employment and is otherwise eligible for Medicaid, except for income, review the MIWD Eligibility Process Guide prior to approval.
5	**Change Medical Category:**	• Change medical category (MAGI, NON-MAGI, Combined).
6	**Notices:**	• Generate and Send Notice of Action to individual(s). o If completing a renewal and the individual remains eligible, ensure the Medicaid Renewal Notice Language is included on the notice. o If a notice is generated for "*Failed to Provide Information"*, staff may communicate missing information.
7	**Narrate:**	• Narrate – include information that explains the actions taken in a way that others can follow the work completed on the case.
PROCESS COMPLETE		

MEDICAID POSITION NUMBERS FOR CASE ASSIGNMENTS

- All referrals to a position number for assignment must be narrated. The narrative must include the reason for the referral. Application Managers do not need to narrate unless there are special circumstances.
- All position numbers must be cleared daily and cases assigned within two business days.
- See Medicaid Position Numbers for Case Assignments.

APPLICATION DENIED FOR "*FAILED TO PROVIDE INFORMATION*"

- If an application is being denied for "*Failed to Provide Information"*, comments may be included on the Notice as to what information is still missing on the case and the timeframe the individual has to provide before a new application is necessary (90 days from application date).
  - **477 NAC 3-005.06** – NEW APPLICATION: A new application is required after 90 days of ineligibility.
  - Use the Calculator for Days 30, 45, 60 and 90 for help in calculating the correct date and see Is a New Application Needed for further information.
- If an application was denied for "*Failed to Provide Information"* and the applicant has turned in verifications within 90 days of the application date, determine if all requested verifications were turned in. See 90 Day Redetermination Examples for further information.
  - If all necessary verifications **were received**, close the VR and re-pend and process the case from the application month.
    - Review the application to determine if there was retroactive Medicaid requested. Remember to process the retroactive months as well as application month forward if all verifications have been provided. See the Retroactive Medicaid Process for further information.
      - If you cannot process the retroactive months but can process from application month forward notify applicant of how many days they have left to provide verifications for the retroactive months, and what verifications are still needed. Do not pend the retroactive months until an eligibility determination can be made (eligible or ineligible).
  - If all necessary verifications **were not received**, do not re-pend the case. Send a speednote stating what information is still needed on the case and the timeframe the HH has to provide information before a new application is necessary (90 days from application date).

MAGI, NON-MAGI AND COMBINED DESK RENEWAL & PAPER RENEWAL PROCESSING

MAGI Desk Renewal & Paper Renewal Process:

See the **MAGI Renewal Process Guide.**
The purpose of the MAGI Renewal Process Guide is to give a step by step process to completing a renewal on individuals in MAGI Medicaid.

Non-MAGI & Combined Desk Renewal & Paper Renewal Process:

See the **Non-MAGI & Combined Renewal Process Guide**
The purpose of the Non-MAGI and Combined Renewal Process Guide is to give a step by step process to completing renewals on individuals in a Non-MAGI or Combined Medicaid case.

Interim Desk Renewal Process (MAGI, Non-MAGI & Combined):

Beginning 4/1/2023, the Interim Desk Renewal process must be followed when processing the annual Medicaid renewal. Individuals must not be closed for failure to provide a renewal form, prior to a desk renewal being attempted. This applies to individuals in MAGI, Non-MAGI and Combined cases. See the following documents on MERL for further information:

- **Policy Log 23-05 MAGI and Non-MAGI Desk Renewals**

Renewals at the Individual Level (MAGI, Non-MAGI & Combined):

Beginning 10/1/2023, Medicaid renewals must be processed at an individual level rather than at the household level. This applies to individuals in MAGI, Non-MAGI and Combined cases. See the following documents on MERL for further information:

- **Policy Log 23-13 Renewal Requirements at the Individual Level**

Effective 9/1/2025, the following renewal documents were archived. All process steps from these documents have been moved into the applicable Renewal Process guides linked above.

- Interim Desk Renewal Process Guide
- Interim Desk Renewal Workflow
- Renewals at the Individual Level Interim Guide