Retroactive Medicaid

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Purpose

- How to apply Nebraska Medicaid policies to retroactive Medicaid;
- Review how to verify earned income and resources for retroactive Medicaid;
- How to determine a resource spend down;
- When to pend retroactive Medicaid; and
- Provide an overview of how to process retroactive Medicaid.

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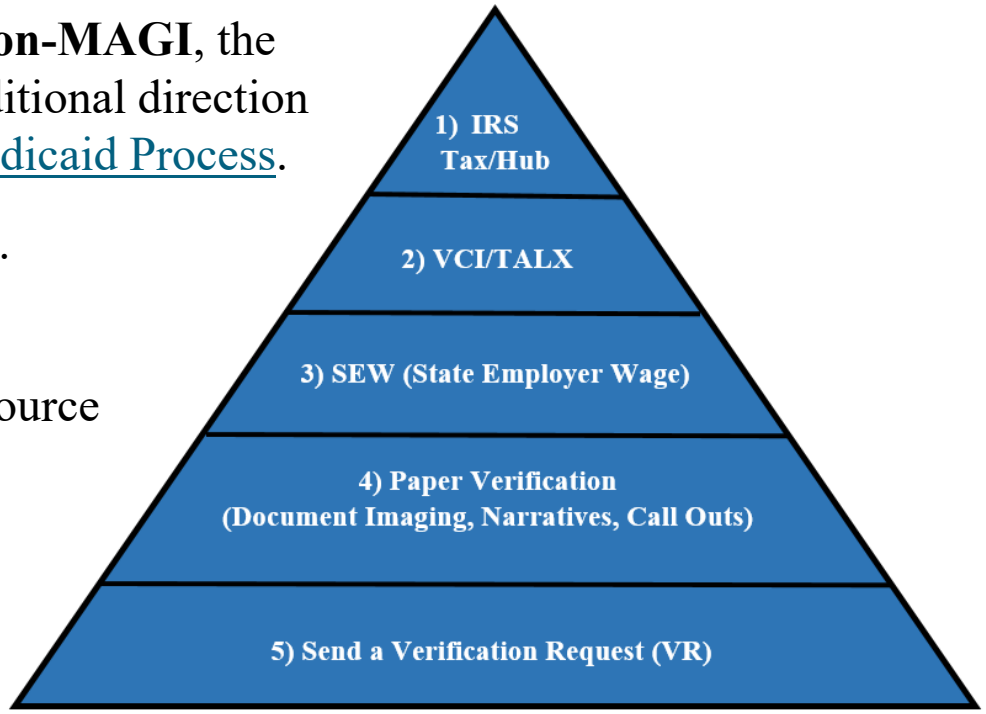
Processing Retro Medicaid based on the Income Hierarchy

- When determining income eligibility for an applicant, **either MAGI or Non-MAGI**, the income must be verified according to the Nebraska Verification Plan. Additional direction can be found in the Medicaid Income Handling Guide and Retroactive Medicaid Process.
- Electronic interfaces should be utilized for retroactive months, if available. See 477 NAC 16-001.14



  - **IRS Tax/HUB:** Unless the household has indicated that the income source is new, the Tax/Hub must be used as the first verification source.
  - **VCI/TALX:** When using VCI/TALX, actual gross income must be used for each retroactive month.
  - **SEW:** When using SEW, compare the attested income to the most recent SEW quarter. The most recent SEW quarter available can be used even if the retro month being budgeted does not fall within the SEW quarter.

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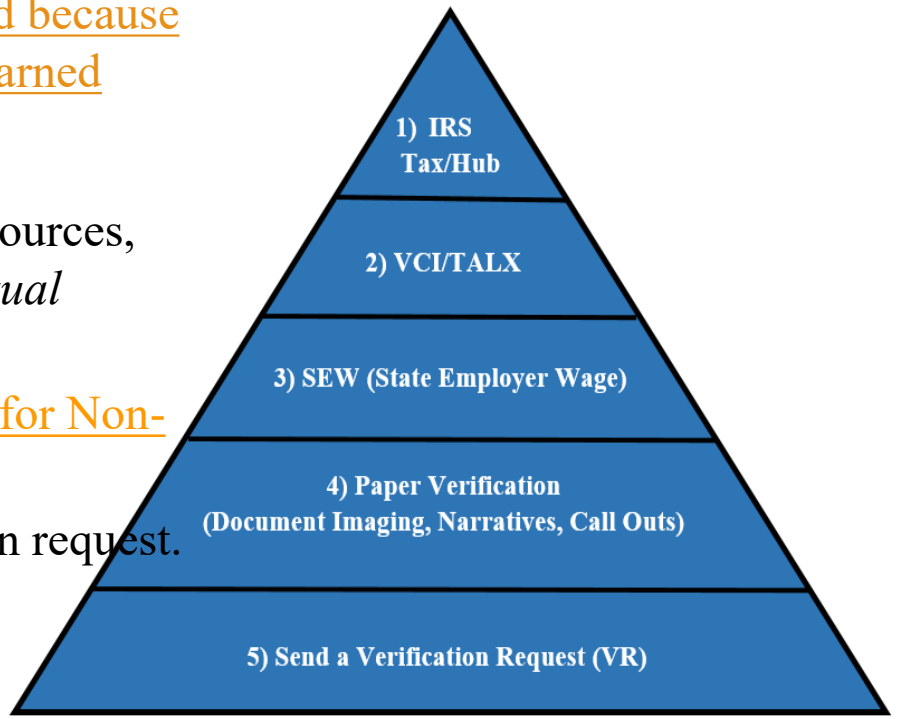
Processing Retro Medicaid based on the Income Hierarchy, *cont.*

- If a lead shows that the income is seasonal, additional follow-up would be required because income should also be annualized for retro budgets; this applies to earned and unearned income sources.

- If you cannot verify income for the retroactive months using available electronic sources, request further information via a Verification Request (VR). Be sure to request *actual* income received for each retroactive month or annualized income if it is seasonal.
  - **NOTE**: annualized income is allowable for MAGI and potentially allowable for Non-MAGI.
  - This will need to be explained to the client in the comments of the verification request. See Words to Work By for further information.
  - A VR due date may be 15 days or 30 days depending on the case situation. For additional information, see the Retroactive Medicaid Process



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Using Self-Employment for Retroactive Medicaid

- If the **tax return** is provided, the pro-rated annualized amount must be used in the Retroactive Medicaid budget.
- If using self-employment **ledgers**, actual income should be used for the SE in the retro months.
  - Each month would have to be entered separately in the Other Income task for each of the retro months. Moving forward, the averaged amount should be used for prospective eligibility.
  - If a lead shows that the income is seasonal, additional follow-up would be required because income should also be annualized for retro budgets; ***this applies to earned and unearned income sources***. **NOTE**: annualized income is allowable for MAGI and potentially allowable for Non-MAGI.
- See 477 NAC 16-001.14: To determine retroactive medical eligibility, each month's actual income shall be used unless an electronic data source is available and is reasonably compatible with the individual's attested income.

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Pending and Processing Retro Requests

- When all verifications are received to process the retro Medicaid request, pend the retro Medicaid case.
    - A retro Medicaid program case is only pended in NFOCUS when an eligibility determination can be completed (approval or denial). All retro months must be processed in one retro Medicaid program case.
- Add any administrative roles to the retro Medicaid program case.
    - This can be found on the application or in the pending or active Medicaid case.
- Run budgets for all retro months requested to determine eligibility.
- Send notice to the individual(s) and administrative role(s).
    - Every retro Medicaid request must have a notice sent when eligibility is determined. This includes approving or denying the retro Medicaid request.

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Retro Medicaid Notices

Every retro Medicaid request must have a notice sent when eligibility is determined. This includes approving or denying the retro Medicaid request. The notice must go to the individual and any Administrative Roles, if applicable.

- If requested verifications are not received, pend and deny the retro Medicaid case for *Failure to Provide* (FTP). This should only be done once the Verification 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 client if needed.
- If a request for retro is withdrawn by the individual, pend and deny the retro Medicaid case for *Client Request* and send a notice.
- If the attested income is over the FPL, pend the case, enter the information into NFOCUS Expert to allow NFOCUS to determine eligibility. The system will deny for Over Income and create a notice.
- See the Retroactive Medicaid Process for situations which do not allow a case to be pended or a notice sent. A Generic Notice must be sent in those circumstances.

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Initial Application Denied for Failure to Provide

- If an application month was denied for failure to provide and the applicant has turned in verifications ***within 90 days*** of the application date, determine if Retroactive Medicaid was requested on the original application.
- Process the retroactive months as well as application month forward, if all verifications have been provided.
- If you cannot process the retroactive months but can process from the application month forward, notify the applicant of how many days they have left to provide verifications for the retroactive months, and what verifications are still needed.
    - The individual has 6 months from the initial application date to provide required verification and have retro Medicaid eligibility determined.

- Make sure to send a notice of action (NOA) if the case is approved or denied. If the client rescinds the Retroactive Medicaid request, the case must still be pended and then denied per *Client Request*. Review the NOA to ensure the manual references are accurately applied.

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Retroactive Medicaid for Non-MAGI Cases

- Determine whether the client has requested Retroactive Medicaid by reviewing the application.
- Submit AVS request by following the AVS Procedural Guide and review the Medicaid Resource Verification Plan.
- If there are any unanswered questions, blank/skipped questions, or clarification is needed:
  - Attempt a call out to the applicant to obtain or clarify the blank/skipped questions or to clarify the confusing answers with the applicant, as we want to refrain from sending a generic verification request.
  - If contact is made, document each of the questions asked and answered by the client. Ask clarifying questions on the resource(s), so there is no question left about the owner(s), value, account/policy number, and financial institution.
  - If no contact was made document when and why contact was attempted. A detailed VR will need to be created, requesting an answer for each question that was missed.
  - Request all other verifications needed in order to process budgeting for each retroactive month.
- Follow the Nebraska Verification Plan and Unanswered Questions documents for additional information.

Reminder: Do not pend Retro Medicaid until the request can be processed or denied.

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Non-MAGI: Resource Spenddown for Retro Medicaid

Eligibility can be processed when all resources, income, and if need be medical expenses have been verified. If the client will be denied due to excess resources, determine whether prior medical bills will reduce the resources prior to denying eligibility (477-000-034 Resource Spend down)

- *If* the applicant/household is over resources for any of the retro months or application month, determine the amount over resources.
  - Once known, speak with the applicant(s) about medical expenses that occurred in the retro months.
  - Determine if the attested expenses offset the amount of excess resources bringing the total resources at or below the maximum allowed.
  - If the expenses will off set the resources, request verification of expenses accordingly.
    - Examples of applying a resource spend down can be found at 477-000-034

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Non-MAGI: Resource Spenddown for Retro Medicaid – cont.

- If there is a monthly share of cost, the amount of the reduction of resources will need to be added to the SOC. The amount of reduction of resources will then be closed for the next month to return the SOC to the original amount.
- Additional examples of the actions above can be found at 477-000-034
- All retro months must be processed within one Retroactive Medicaid program case.

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Helpful Hints or Reminders

- Clients may request Retroactive Medicaid within six months of their initial application, even if they did not indicate a retroactive need on the application.
  - The individual has 6 months from the initial application date to provide required verification and have retro Medicaid eligibility determined.
- A Retro Medicaid program case will not be pended in NFOCUS until an eligibility determination can be completed (approval or denial).
- Any Authorized Rep/Admin Role must also be added to the Retro Medicaid case.
- There is no Retro Medicaid eligibility for 599 CHIP cases.
- Electronic data sources must be used for verification of retroactive months prior to requesting paper verification.
  - The most recent SEW report can be used even if that quarter does not line up with the retroactive month(s) requested.
- If eligibility can only be determined by paper documentation (paystubs, SE ledgers) actual income must be used for processing except for cases with seasonal income.

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Questions or comments? DHHS.MedicaidQA@Nebraska.gov

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