

Phase II - Module 11 - 12

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Please make use of all job aids, forms, notices, and supporting documentation related to these modules.

Factors to Consider When Addressing Reported Changes for a Beneficiary

There are several factors that determine if, how, and when to address reported changes for a beneficiary:

- 1. What is the reported change?**
- 2. Does the change affect the beneficiary’s Medicaid eligibility according to policy?**

- Is the beneficiary over or under age 19?
- Is the beneficiary receiving MPW?

3. What is the timing of the change?

- Is this an ongoing change or a retroactive change?
- Was the change reported timely (within 10 calendar days)?

4. Who reported the change?

- Was this reported by the beneficiary, a legal/authorized representative, or someone else?

Reporting Changes

- Changes can be reported while an application is pending, during the certification period, or during the recertification period.
- Beneficiaries are required to report all changes within 10 calendar days of the change.
- Beneficiaries should report any changes to their situation. The caseworker will determine if and how to address these changes for the beneficiary's eligibility.
- When a change in situation is reported, the caseworker should ask if there are any other changes that have occurred in the beneficiary's situation.

How a Change Can Be Reported

Changes can be reported through various methods, including but not limited to:

- Via phone, email, or in-person
- Via application submitted
- Via linked ePASS account

Timeframe for Action

Appropriate action on any changes should be completed within 30 calendar days from when the Agency learns of the change. This applies whether the change was reported by the beneficiary or discovered by the Agency through other means.

Common Changes

Many changes can impact a beneficiary's eligibility, including but not limited to:

- Change of address (in-state or out-of-state)
- Change in household composition (someone entering or leaving the household)
- Change in living arrangement
- Change in relationship status

- Change in income or employment status
- New or terminated pregnancy
- Changes in tax filing or dependent status
- Critical age changes

Changes that Negatively Impact Eligibility

When a change is discovered that could negatively impact Medicaid eligibility, and the NCF-20020 prepopulated Medicaid Renewal form is required, consider the following changes to the most recently known and verified household situation:

Income:

- Self-employment
- New income
- Decreased or increased income
- Terminated income

Electronic Sources:

- Indicate that benefits will decrease or reduce.
- Indicate that the beneficiary is ineligible for all Medicaid programs.

Household Changes:

- Tax filer status
- Household composition changes that may impact eligibility

Marital Status Changes:

- Newly married, widowed, separated, or divorced

Understanding the Month of Change

The month of change is defined as the month in which the change occurred, not the month it was reported. This applies to all types of changes.

Factors Determining When a Change is Effective

- **Current Benefit:** What is the beneficiary's current benefit?
- **Timing:** When did the change occur versus when it was reported?
- **Impact:** Would the change result in a reduction or termination of benefits?

Income Changes

Income changes are defined as:

- New, different, or additional sources of income/employment

- An increase or decrease in the rate of pay
- An increase or decrease in the required number of hours worked
- Termination of income

This applies to both earned and unearned income types.

- **New Income for CoCs:** Income that was not previously available to the household but is now or will be available during the remainder of the certification period (CP).
- **Terminated Income for CoCs:** Income from a source that has already ended, even if the individual has not received their final pay.
- **Fluctuating Income:** Fluctuating income is not considered a change.

The type of income change determines how it is addressed for a CoC.

MAGI – Processing Changes

A Medicaid beneficiary must receive notice of the outcome of any eligibility redetermination, regardless of the reason or result. The caseworker is responsible for sending a notice to the beneficiary, informing them of the continuation, reduction, or termination of their Medicaid benefits. This applies to redeterminations at the end of a certification period (Recertification) and any re-evaluation prompted by a Change of Circumstance (CoC) during the certification period.

Step 1: Complete Redetermination

Possible Outcomes:

1. Continued Eligibility:

- The beneficiary remains eligible for coverage.
 - This may be at the same benefit level as before the re-evaluation (though not necessarily the same aid program/category).
 - This may result in an increased benefit level.
 - This may result in a reduced benefit level.

2. Ineligibility:

- The beneficiary is no longer eligible for Medicaid coverage.

Notification Form:

DSS-8110 Notice of Modification, Termination, or Continuation of Benefits is used to notify the beneficiary of the redetermination outcome, whether it is a recertification or CoC (or a follow-up to a post-eligibility request). **This form can indicate:**

- Continuation of eligibility
- Change in eligibility (increase/reduction)
- Termination of eligibility

Based on the redetermination outcome, the caseworker must determine if the notification is Adequate or Timely. Whenever possible, the DSS-8110 should be generated in NC FAST.

Adequate vs. Timely Change

Adequate Change	Timely Change
<ul style="list-style-type: none"> • “Adequate” notification is used any time the beneficiary will either remain on the same benefit level or a transfer to a “better benefit” (increase in benefits). • The beneficiary must be informed <u>in writing</u> of a change in benefits prior to the change. • The date the Adequate notice is mailed is the date the change will be processed in NCFast. The effective date of the change is dependent upon if the change will be a continuation, increase, reduction or termination. • An “adequate” change to a case means that there is no need per policy to give the beneficiary timely notice of the change to their Medicaid - the adequate action may take place immediately. The notification and the change may happen simultaneously. 	<ul style="list-style-type: none"> • “Timely” notification is used any time the beneficiary will either reduce in benefit or their Medicaid benefits will be terminated, except for situations noted in policy. • A “timely” change to a case means that the beneficiary must be given 10 business days’ notice prior to the action taking effect on their case. This gives the beneficiary time to dispute the action and/or request that their benefits continue until their first hearing date. • The date the change will be processed in NC FAST will be the first business day after the date the timely notice expires. The effective date of the change depends on if the change will be a reduction or termination. • During the timely notice period, the beneficiary may request a hearing and that their benefits continue until the first hearing date.

Step 2: Determine whether notice is Adequate or Timely

Adequate DSS 8-110

- Continued coverage results in the same benefit level for the beneficiary.
- Continued coverage results in an increase in Medicaid benefit level.

Timely DSS-8110

- Continued coverage results in a reduction in Medicaid benefit level.
- Beneficiary is no longer eligible for continued Medicaid coverage (with exceptions).

Generating the DSS-8110 in NC FAST

Once all evidence has been managed, necessary verifications added, and changes applied, the case should be placed “on-hold” with the new eligibility determination.

1. **Navigate to the Eligibility Tab** on the Insurance Affordability case. This will display the new on-hold decision. Do **not** accept the hold without first reviewing the eligibility determination for accuracy.
2. **Confirm the on-hold decision** is correct, then click the List Actions Menu next to the decision.
3. **Accept the hold** either Timely or Adequately, depending on whether the beneficiary's Medicaid benefit is continuing, changing, or terminating.
4. A pop-up will appear asking if you are sure you want to accept the decision either Timely or Adequate, based on your selection. Choose the applicable answer.
5. The **Create 8110 Wizard** will appear. Enter the necessary information and click Next.
6. **Verify the information** for accuracy. If everything is correct, click Save.

Generating the DSS-8110 in NC FAST

Before creating and sending the DSS-8110, ensure you have updated and verified any necessary evidence, applied changes, and checked your eligibility determination.

1. **Navigate to the Case Details Tab** on the PDC and select the Communications folder.
2. Click on the **Page Actions Menu** and select "New Pro Forma."
3. Select the **Case Head** as the Case Participant, then click Next.
4. The **New Pro Forma Communication** screen will appear. Select **Notice** as the Type, then click Search.
5. Scroll down and click **Select** next to the appropriate DSS-8110 notice you wish to create.
6. Choose whether the notice should be **Adequate** or **Timely**, then click Next.
7. **Verify the information** for accuracy. If everything is correct, click Save.

Marking the DSS-8110 as "Sent" in NC FAST

Once the DSS-8110 is generated, it can be found in the PDC under the Case Details Tab in the Communications folder. Initially, the DSS-8110 will have a Communication Status of 'Draft-Central Print,' indicating it has been generated but not yet sent.

The caseworker has two options:

- **Leave it in Draft-Central Print:** The system will mail the notice on the next business day and update the Communication Status to "Sent-Central Print."
- **Send it manually:** The caseworker can print and mail the notice themselves, then mark it as "Sent" in NC FAST to prevent the system from sending it the next business day.

To manually mark the DSS-8110 as "Sent":

1. Click on the **List Actions Menu** for the DSS-8110 notice.

2. Click **Edit** and ensure the populated address is correct for the case head.
3. Update the **Communication Status** to “Sent.”
4. Click **Save**.
5. The **Communication Status** for the notice will now show as “Sent.”

Example: Removing a Household Member

A common change encountered as caseworkers is removing a household member from an active case/application.

There are several reasons we may need to remove a household member from a case. These include but, not limited to:

- Someone moves out of the household
- Someone is deceased
- Someone is no longer required to be on the case due to age of the beneficiary and/or tax filing dependent status changes
Refer to MAGI-Removing a Person from an Insurance Affordability job aid for additional information.

Step-by-Step Instructions

1. Navigate to the applicable **Insurance Affordability** case.
2. Click the **Evidence Tab**.
3. End-date each piece of evidence for the person as appropriate:
 - Use the actual day of the month, the person left the household as the end date.
 - Evidence to end-date may include, but is not limited to:
 - Application details
 - Member relationships
 - Primary care provider – NC Medicaid Direct
 - Residency
 - Income, Deductions, Excluded Income
 - Applicant Filer Consent
 - Participant Address
 - Tax Filing Status/Tax Relationship
 - **Case only** – delete Contact Preferences (do not delete on person page)
 - Never delete the following evidence:
 - SSN Details
 - Date of Birth/Date of Death (unless the client is deceased)
 - Citizenship/DHSID Details
4. Add verifications for end-dated evidence, such as residency and income.
5. Click the **Page Actions Menu** and select **Apply Changes**.
6. Navigate to the **Participants Tab**:

- The system may automatically end-date the individual on the Participants Tab so they no longer display on top of the Insurance Affordability. If not, do the following:
 - Click the list of actions on the Menu next to the case Member you want to end-date and select Edit.
 - Add an End date and End Reason.
 - Click Save.
- 7. Click the **Eligibility Tab** and review the on-hold determination.
- 8. If the on-hold decision is correct, select **Accept with Timely** or **Accept with Adequate** as appropriate. DSS-8110 must be sent to notify the beneficiaries of any continuation, change, or termination of benefits.

Documentation

Reporting changes for Modified Adjusted Gross Income (MAGI) is crucial for clients under the North Carolina Department of Health and Human Services (NCDHHS) for several reasons:

1. **Accurate Eligibility Determination:** Changes in income, household composition, or employment status can significantly impact a client's eligibility for Medicaid benefits. Accurate reporting ensures that clients receive the correct level of benefits they are entitled to.
2. **Compliance with Federal Regulations:** Federal regulations mandate that eligibility be evaluated annually. Reporting changes promptly helps maintain compliance with these regulations and avoids potential penalties or loss of benefits.
3. **Efficient Resource Allocation:** Accurate reporting allows NCDHHS to allocate resources more efficiently, ensuring that those who are most in need receive timely assistance.

For case workers, reacting to these changes is equally important:

1. **Timely Adjustments:** Caseworkers need to promptly update client records to reflect on any changes. This ensures that clients receive the correct benefits without delays or interruptions.
2. **Preventing Fraud and Abuse:** By verifying reported changes, caseworkers help prevent fraud and abuse within the system, ensuring that benefits are distributed fairly and appropriately.
3. **Client Support and Guidance:** Caseworkers play a vital role in guiding clients through the process of reporting changes and understanding how these changes affect their benefits. This support helps clients navigate the system more effectively and reduces the likelihood of errors.

Overall, the collaboration between clients and caseworkers in reporting and reacting to changes is essential for maintaining the integrity and efficiency of the Medicaid program.

If you have any specific questions or need further details, feel free to ask!

Cited Sources

NC FAST Phase I Training Curriculum

NCDHHS Website [NC DHHS: North Carolina Department of Health and Human Services](#)

Buncombe County Department of Social Services Training Curriculum

NC FAST HELP

https://ncfasthelp.nc.gov/FN_B/FN_B/server/general/projects/FAST_Help/FAST_Help.htm