

DMA ADMINISTRATIVE LETTER NO: 01-14, AFFORDABLE CARE ACT (ACA) OVERVIEW OF MEDICAID CHANGES

DATE: 02/03/2014

SUBJECT: Affordable Care Act (ACA) Overview of Medicaid Changes

DISTRIBUTION: County Department of Social Services
Medicaid Supervisors
Medicaid Eligibility Staff

I. BACKGROUND

The Patient Protection and Affordable Care Act of 2010, also referred to as Health Care Reform, expands health coverage while making improvements to eligibility and enrollment policies for Medicaid and NC Health Choice. Provisions under the Affordable Care Act have resulted in significant changes to North Carolina's Medicaid Program. Some of these changes include expanding program groups and streamlining the application process.

The purpose of this administrative letter is to highlight some of the changes to Medicaid eligibility. Although most of these changes did not take place until January 1, 2014, the Affordable Care Act required states to begin taking applications under this law beginning October 1, 2013.

II. CONTENT OF CHANGE

A. Pregnant Women

Under the Affordable Care Act, certain rules for Pregnant Women have changed.

1. A self-attestation of pregnancy and due date can be accepted as proof of pregnancy unless the county has information that contradicts the attestation. (For example: The individual states they have been pregnant for 12 months).
2. Certification period for MPW is still the first month of eligibility through post-partum.
3. If an applicant is unsure of the due date, the County DSS must request information. Follow application processing requirements for requesting information. If the information is not provided, deny the application. A certification period cannot be given without a due date.
4. A Pregnant woman is counted as one plus the number of unborn(s) when determining household and family size to determine her eligibility for MAGI programs. Refer to [DMA Administrative Letter 06-13](#).

5. When determining household size for a pregnant woman, count the unborn as one unless there is verification of multiple unborn(s). Do not accept a self-attestation for multiple unborn(s).
6. When the pregnant woman is included in the household and family size of another individual, she is counted as one. Do not include the unborn(s).

B. Post Eligibility Verification

Certain factors must be verified post eligibility for MAGI programs. Information on a non-custodial parent and third party insurance is not required prior to an eligibility determination.

1. Do not request verification of information on a non-custodial parent prior to approving an application.
 - a. Once the application has been approved, send the DMA-5097, Request for Information, allowing the beneficiary 12 calendars days to provide information.
 - b. If requested information is not received, send a timely notice proposing termination for failure to provide necessary information.
2. Do not request third party insurance information prior to approving a Medicaid application.
 - a. Once the application has been approved, send the DMA-5097, Request for Information, allowing the beneficiary 12 calendars days to provide information.
 - b. If verification is not received, send a timely notice proposing termination for failure to provide necessary information.
 - c. If third party insurance information is provided during the interview or the application process, key the information in the system.

Note: NC Health Choice beneficiaries are not eligible if covered by comprehensive insurance.

3. Individuals applying for coverage are required to apply for all benefits to which they might be entitled, such as unemployment benefits or RSDI. However, it is not required prior to an eligibility determination.
 - a. If the caseworker determines an individual is potentially eligible for a financial benefit, but is otherwise eligible for Medicaid, approve the application. After approval, send the DMA-5097, Request for Information, allowing the beneficiary 12 calendars days to provide verification they have applied for potential benefits.

- b. If verification is not received, send a timely notice proposing termination for failure to provide necessary information.
- c. For unemployment benefits, if the applicant has not applied timely, do not count any phantom benefits. MAGI rules do not allow counting income that is not received.

C. State Residency

An applicant must live in North Carolina and meet all other eligibility requirements in order to receive NC Medicaid benefits.

1. An individual is a resident of North Carolina if:
 - a. He is living and intends to reside in the state, even if he has no fixed address, (previous regulations required the individual to state intent to remain), or
 - b. Has entered NC to seek employment or with a job commitment.
2. An individual under 21 in NC only to attend school is a resident if:
 - a. He lives in NC independently from his parent(s)' support and care, including tuition and living expenses, and
 - b. Does not regularly return to his parent(s)' home with the intent to live, and
 - c. He is not claimed as a tax dependent by an individual who is a resident of another state.

D. Former Foster Care Children (MFC) and Expanded Foster Care Program (EFCP)

DMA Administrative letter 14-13, Medicaid to Former Foster Care Children (MFC), contains eligibility requirements for a new mandatory group required by the Affordable Care Act (ACA). Although the policy principles and eligibility requirements are similar, MFC and the Expanded Foster Care Program are separate programs.

1. The eligibility requirements for EFCP have not changed. See [MA-3230](#), Individuals Under Age 21. Eligible children are ages 18, 19, and 20. For MFC, eligible children are age 18 to 26.
2. For EFCP, it does **not** matter what state he was in foster care at age 18. For MFC, the child must have aged out of foster care in NC and been enrolled in NC Medicaid when he turned 18.
3. If a child is receiving EFCP and turns age 21, evaluate for MFC if all eligibility requirements are met. If not eligible for MFC, evaluate for all other Medicaid programs.

E. Electronic Verification

When determining eligibility for Medicaid/NCHC under MAGI rules, verification from an electronic source must be used first.

1. Only request additional verification from the a/b if:
 - a. There is no electronic source available. (e.g. landlords, utility companies, or a new employer), or
 - b. There is inconsistency between the electronic source and the a/b's self-attestation that can have an impact on eligibility.
2. If requesting additional verification, send the DMA-5097, Request for Information, allowing the applicant 12 calendars days to provide information. Follow application processing requirements for requesting information.
3. If verification is not received, deny the application for failure to provide necessary information.
4. For ongoing cases, send the DMA-5097, Request for Information, allowing the applicant 12 calendars days to provide information.
5. If verification is not received, send a timely notice proposing termination for failure to provide necessary information.

III. EFFECTIVE DATE AND IMPLEMENTATION

This policy is effective January 1, 2014.

If you have any questions regarding this information, please contact a Medicaid Program Representative.

Sandra Terrell, MS, RN
Acting Director

(This material was researched and written by Ena Lightbourne, Policy Consultant, Medicaid Eligibility Unit)