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101.01 Introduction

(Eff. 01/01/14)

This chapter provides guidelines for processing eligibility determinations for all Medicaid coverage groups.

**101.02 Definitions**

(Eff. 01/01/14)

**101.02.01 Applicant**

(Eff. 01/01/14)

An individual whose signed application for Medicaid has been received by the South Carolina Department of Health and Human Services (SC DHHS).

**101.02.02 Authorized Representative**

(Rev. 09/01/17)

An Authorized Representative is an individual granted authority to act via [SC DHHS Form 1282](http://medsweb.scdhhs.gov/EligibilityForms/FM%201282%20ME.pdf), Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications Reviews and Appeals, who is acting for the Applicant/Beneficiary with the Applicant/Beneficiaries’ knowledge and consent and who has knowledge of his circumstances. The DHHS Form 1282 must be signed by the applicant/beneficiary or a legal representative of the applicant/beneficiary to be valid.

The **Authorized Representative** should be informed of his responsibilities for the Medicaid determination and appeals process. The DHHS Form 1282 ME must be given to the Authorized Representative. A copy of all agency communications sent to an applicant/beneficiary, including notices and requests for information, must be sent to the Authorized Representative.

|  |
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| **Examples of an Authorized Representative:*** Relative
* Friend
* Attorney
* Employee of an agency or facility which holds custody (ex. Medical Facility)
* Third Party Medical Service Organization
* Third Party Private Eligibility Service Organization
 |

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| **Procedure for Recognizing an Authorized Representative**  |
| **MEDS Procedure** Scan any documents related to Authorized Representatives into OnBase as part of the electronic case record. If the Form 1282 is submitted at the time of application, then the Form 1282 should be processed with the Application. If the Form 1282 is submitted after the application is submitted, then scan the Form 1282 into OnBase as a MEDS-Member Verification trailing document. The worker should then enter the Authorized Representative information into MEDS and note on the Documentation Template.**NOTE:** If the SC DHHS Form 1282 is submitted after the application, it should be mailed to:SC DHHS – Central MailP O Box 100101Columbia, SC 29202-3101 **NOTE:** When an application is submitted online, if an Authorized Representative is indicated on the application, the worker must send a DHHS Form 1233 to the applicant to request a signed DHHS Form 1282. Until the signed DHHS Form 1282 or other legal authorization (such as a Power of Attorney) is received, application information cannot be shared with anyone except the applicant, a current spouse, or the parent of a minor child who is shown on the application.* An Applicant/Beneficiary should only have one Authorized Representative designated at a time.
* An Authorized Representative remains valid until the Applicant/Beneficiary or legal representative submits a DHHS Form 1282 which either:
	+ Names a new Authorized Representative; or
	+ Requests removing an AR.

If an Applicant/Beneficiary has two or more Authorized Representatives, enter a note in MEDS and OnBase on the Documentation Template with the additional authorized representative’s information. **Cúram Procedure** The appropriate procedure may be found in the [Authorized Representative Process](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Authorized%20Representative%20Process.pdf?csf=1&web=1&e=zC9wxg) job aid at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/). |

**101.02.03 Beneficiary**

(Eff. 01/01/14)

An applicant approved for and receiving Medicaid benefits.

**101.02.04 Incapacitated Individual**

(Eff. 01/01/14)

An individual unable to act on his own behalf due to a physical or mental condition.

**101.02.05 Incompetent Individual**

(Eff. 01/01/14)

An individual adjudged to be mentally incompetent by a probate court.

**101.02.06 Individual with Limited English Proficiency (LEP)**

(Eff. 01/01/14)

An individual whose primary language is not English and who is not competent enough to communicate in any language other than his native language.

**101.02.07 Sensory Impaired Individual**

(Eff. 01/01/14)

An individual who has a partial, profound, or complete loss of hearing or sight.

**101.02.08 Legal Representative**

(Eff. 06/01/14)

A Legal Representative is a person who has been granted legal authority to look after another’s affairs, such as an attorney, executor, administrator, holder of power of attorney, etc.

A Legal Representative acting on the Applicant/Beneficiary’s behalf through the application and appeals process must:

* Be appointed via the [SC DHHS Form 934-A](http://medsweb.scdhhs.gov/EligibilityForms/FM%20934-A.pdf), Appointment of Applicant’s Legal Representative for Medicaid application and appeals process. (A [DHHS Form 1282](http://medsweb.scdhhs.gov/EligibilityForms/FM%201282%20ME.pdf) or SCDHHS HIP-02 will not be necessary.) However, the [SC DHHS Form 934-A](http://medsweb.scdhhs.gov/EligibilityForms/FM%20934-A.pdf) **is not required** if an attorney is providing legal representation for an applicant in a legal proceeding.
* If an organization, designate an individual appointee to sign the form and communicate with the agency. (**Note:** The Company’s name does not qualify as the signature.)

Obtain the signature of the applicant to allow for the release of protected health information under HIPAA regulations.

**101.02.09 Primary Individual**

(Eff. 06/01/14)

A person who is the primary contact person regarding his and his household’s application. This person may submit an application on behalf of himself; a spouse, who may or may not live in his household; and/or a family member(s) who lives in his household.

**101.02.10 Third Party Applicant**

(Eff. 11/01/15)

A person/entity who submits an application on behalf of another person. The Applicant must be both aware that the Third Party Applicant is submitting an application on his behalf and he must consent to it. (The Eligibility Worker does NOT have to view written consent or contact the Applicant to confirm consent. By signing the application the Third Party Applicant represents that these requirements have been met.) The designation by an applicant or beneficiary is valid until (1) he or she revokes the designation, (2) the designated individual decides to no longer accept the role, or (3) when an application is denied or an ongoing case is terminated, including any appeals or hearings.

**Appointing an Authorized Representative:** Unless (1) the Applicant has completed a SC DHHS Form 1282 naming the Third Party Applicant as an Authorized Representative, or (2) the court has appointed/approved the Third Party Applicant as a legal representative (ex. Power of Attorney), a Third Party Applicant’s authority is limited to submitting an application. Without the aforementioned authorizations, the Third Party Applicant cannot act beyond the application’s submission or receive information about the application/case; i.e., he cannot request information on the status of the application, manage the Applicant’s case, or access his personal information. The Authorized Representative must be entered in MEDS or Cúram and on the Documentation Template in OnBase. An applicant/beneficiary can name more than one person or organization as an Authorized Representative. These must be documented in notes in MEDS or Cúram and in OnBase. A designated Authorized Representative cannot sign a DHHS Form 1282 to appoint someone else to act as an Authorized Representative or to receive information about an application of case.

**Permission to Release Information:** The Applicant may also complete the “Permission to Release Information” section on SC DHHS Form 1282, granting the Third Party Applicant permission to receive information about the application/case without the Third Party being in the position to act on the applicant’s behalf as an Authorized Representative. SC DHHS may release information on the application/case to the Third Party Applicant for the purposes of informing the Third Party of the status of a Medicaid eligibility determination. Document any persons or organizations that an applicant/beneficiary has given permission to receive information in the notes sections of MEDS or Cúram and in OnBase.

**101.03 Application Process**

(Eff. 06/01/14)

Applications may be submitted online, in person, by mail, and by telephone. Locations for local eligibility offices may be found at [County Offices Contact Info](https://www.scdhhs.gov/historic/popupoffices.html). The Healthy Connections Member Service Center will receive calls from citizens who may be seeking assistance to complete the [SCDHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf), Healthy Connections Application for Medicaid and/or Affordable Health Coverage.

All applications for Medicaid should be (i) filed on a SC DHHS approved application form, (ii) be legible, and (iii) should be completed online, in ink, or by typing when possible. A signed and dated application provides a legal document that:

* Clearly signifies intent to apply;
* Puts the Applicant on notice that he/she is liable for the truthfulness of the information on the application;
* May be introduced as evidence in court;
* Provides sufficient information to begin an accurate determination of eligibility; and
* Provides notice to the Applicant of his rights and responsibilities.

Eligibility Staff must accept any valid Medicaid application that is submitted. If additional information is required to process the application for a particular category, it must be requested from the applicant, but the applicant cannot be required to complete an additional application.

**A completed application form must be on file for every Applicant/Beneficiary.** Once a properly signed and dated application has been submitted, the Medicaid Eligibility Worker must not alter the application by adding, changing, or deleting any information. During an interview, an applicant can make changes to the information on an application. The change must be initialed by the Applicant on any submitted paper application. Changes reported to the Eligibility Worker by any other means must be documented in the appropriate MEDS or Cúram Notes screen.

Supplemental Security Income Recipients

* SSI recipients who enter a facility and have their SSI benefits terminated will be required to file a Medicaid application.
* Dual eligibles (recipients of both Retirement, Survivors, and Disability Insurance (RSDI) and SSI benefits) who enter a facility permanently (more than 90 calendar days) and whose RSDI benefit is greater than $50 will usually have their SSI benefits terminated. Therefore, a Medicaid application will be required.

Dual eligibles entering a facility temporarily (less than 90 calendar days) usually continue to qualify for SSI. Therefore, they will not be required to complete a Medicaid application.

**101.03.01 Application Form**

(Rev. 12/01/22)

Applicants may apply for Medicaid using the [DHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf), Healthy Connections Application for Medicaid and/or Affordable Health Coverage. Some specialty programs may require an addendum to collect additional information. An addendum is a supplement to the application and is not a valid application by itself.

* If an application is denied for a reason other than failure to return information, a new application and addendum is required if the applicant wants to apply for Medicaid coverage.
* If an application is denied for failure to return information,
	+ If the applicant provides all the requested information within 30 days from the date on the denial notice, the existing application and addendum is still valid.
	+ If the applicant does not provide all of the requested information within 30 days from the date on the denial notice, a new application and addendum is required.

Applicants applying for a non-MAGI category, Optional State Supplementation (OSS), or General Hospital may apply using the DHHS Form 3400 with the DHHS Form 3400-A, Additional Information for Select Medicaid Programs.

A person applying only for Nursing Home (Institutional), Waiver Services (Waiver), or Optional State Supplementation (OSS) may apply using:

* the [DHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf) with the [DHHS Form 3400-B](http://medsweb.scdhhs.gov/EligibilityForms/FM3400-B.pdf), Additional Information for Nursing Home and In-Home Care, or
* the [DHHS Form 3401](http://medsweb.scdhhs.gov/EligibilityForms/FM%203401.pdf), Healthy Connections Application for Nursing Home, Residential or In-Home Care**.**

Applicants who only want Family Planning and no other coverage may apply using the DHHS Form 400, Family Planning Only Application.

Applicants who only want to be considered for TEFRA may apply using the DHHS Form 3290, TEFRA Application.

Applicants referred by Continuum of Care to apply for the Palmetto Coordinated System of Care (PCSC) waiver can use either the:

* DHHS Form 3400 if applying as part of the family, or
* [DHHS Form 3405](http://medsweb.scdhhs.gov/EligibilityForms/Form3405_Single%20Person_HH.pdf), Healthy Connections Medicaid Application - Single Person Household, if only the child who needs PCSC waiver services is applying.

**101.03.02 Choice of Category**

(Rev. 12/01/19)

CFR [§435.907](http://www.ecfr.gov/cgi-bin/text-idx?SID=1b4fd0b5e9cdf2a1c8958e150774f5c3&node=42:4.0.1.1.6.10.72.8&rgn=div8)

The Eligibility Worker should advise the Applicant which category of assistance may be the best choice based on a review of the family's circumstances. If the Applicant would likely be eligible under numerous coverage groups, the Medicaid Eligibility Worker should explain which coverage group is more appropriate and the associated advantages of that group. If an Applicant meets the eligibility criteria of more than one coverage group, he/she generally has the option to choose the group under which eligibility is established.

Applicants are allowed to apply for streamlined Medicaid (MAGI) and/or the Non-MAGI Medicaid program of their choice. If an applicant insists on applying for Medicaid under a specific category of assistance, he/she must be given the opportunity to have eligibility determined using the criteria for that category. The individual will be approved only for one payment category.

If a current Medicaid Beneficiary seeks assistance under another category, a new application is not required. The Eligibility Worker must evaluate the application on file, and request any additional information needed to determine if the beneficiary meets the eligibility criteria for the new category.

|  |
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| **Exceptions:*** Supplemental Security Income (SSI) recipients - Applications maintained by the Social Security Administration
* SSI recipients entering a nursing facility or the Home and Community-Based Services waiver program who will continue to qualify for SSI
* Title IV-E Foster Care beneficiaries
* Title IV-E Adoption Assistance beneficiaries
 |

| **an application****OR REQUEST****for . . .** | **payment category** | **should be****received and****processed****by . . .** | **recommended****application****form** |
| --- | --- | --- | --- |
| Adoption Assistance (Title IV-E) | 51 | Local eligibility worker  | No application form necessary |
| Adoption Assistance (Special Needs/-Subsidized) | 13 | Local eligibility worker  | [DHHS Form 3400](http://medsweb.scdhhs.gov/EligibilityForms/FM3400.pdf), Healthy Connections Application |
| Aged, Blind, and Disabled (ABD) | 32 | Local eligibility worker  | DHHS Form 3400 and [DHHS Form 3400-A](http://medsweb.scdhhs.gov/EligibilityForms/FM3400-A.pdf), Healthy Connections Additional Information for Select Medicaid Programs |
| ABD-Nursing Home (ABD-NH) | 33 | Local eligibility worker | [DHHS Form 3401](http://medsweb.scdhhs.gov/EligibilityForms/FM%203401.pdf), Healthy Connections Application for Nursing Home, Residential or In-Home Care ORDHHS Form 3400 AND[DHHS Form 3400-B](http://medsweb.scdhhs.gov/EligibilityForms/FM3400-B.pdf), Additional Information for Nursing Home and In-Home Care |
| Breast and Cervical Cancer Program (BCCP) | 71 | Received by: BestChance Network (BCN), Local Eligibility Worker or Division of Central Eligibility Processing (DCEP)Processed by: DCEP | DHHS Form 3400 and DHHS Form 3400-A |
| Disabled Adult Children (DAC) | 19 | Local eligibility worker  | DHHS Form 3400 and DHHS Form 3400-A |
| Disabled Widows/-Widowers (DWW) | 18 | Local eligibility worker  | DHHS Form 3400 and DHHS Form 3400-A |
| Elderly Widows/-Widowers (EWW) | 17 | Local eligibility worker  | DHHS Form 3400 and DHHS Form 3400-A |
| Essential Spouse (ES) | 81 | Local eligibility worker  | DHHS Form 3400 and DHHS Form 3400-A |
| Family Planning (FP) | 55 | Local eligibility worker | DHHS Form 3400 |
| Foster Care (Title IV-E) | 31 | Local eligibility worker  | No application form necessary |
| Foster Care - Regular (RFC) | 60 | Local eligibility worker  | DHHS Form 3400 |
| General Hospital (GH) | 14 | Local eligibility worker | DHHS Form 3400 AND DHHS Form 3400-A |
| Partners for Healthy Children (PHC) orIn Cúram - Child | 88 | Local eligibility worker | DHHS Form 3400 |
| Parent/Caretaker Relative (PCR) orLow Income Families (LIF) | 59 | Local eligibility worker | DHHS Form 3400 |
| Nursing Home – No SSI | 10 | Local eligibility worker | DHHS Form 3401ORDHHS Form 3400 AND DHHS Form 3400-B |
| Nursing Home for SSI Recipient (SSI-NH) | 54 | Local eligibility worker | No application form necessary  |
| Income Trust – Nursing Home & HCBS | 10, 15 | Local eligibility worker  | DHHS Form 3401ORDHHS Form 3400 AND DHHS Form 3400-B |
| Pass-Along (Pickle) | 16 | Local eligibility worker  | DHHS Form 3400 and DHHS Form 3400-A |
| Pass-Along Children (PAC) | 20 | State Office completes ex parte determination when child reaches age 18. | (Refer to category to which child is being “ex parted.”) |
| Pregnant Women and Infants (PW) orOptional Coverage for Women and Infants (OCWI) | 12, 87 | Local eligibility worker  | DHHS Form 3400 |
| Optional State Supplementation (OSS) - No SSI | 85 | Local eligibility worker | DHHS Form 3401ORDHHS Form 3400 AND DHHS Form 3400-B |
| Optional State Supplementation (OSS) for SSI recipient | 86 | Local eligibility worker | [DHHS Form 1728 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201728%20ME.pdf)SSI Recipient Request for OSS |
| Qualified Disabled Working Individuals (QDWI) | 50 | Local eligibility worker | DHHS Form 3400 and DHHS Form 3400-A |
| Qualified Medicare Beneficiaries (QMB) | 90Not a current PCAT | Local eligibility worker  | DHHS Form 3400 and DHHS Form 3400-A |
| Qualifying Individuals (QI) | 48 | DCEP(Eligibility is determined during the limited enrollment period) | DHHS Form 3400 and DHHS Form 3400-A |
| Refugee Assistance | 70 | Local eligibility worker  | DHHS Form 3400 |
| Ribicoff | 91 Not a current PCAT | Local eligibility worker | DHHS Form 3400 |
| Specified Low Income Medicare Beneficiaries (SLMB) | 52 | Local eligibility worker  | DHHS Form 3400 and DHHS Form 3400-A |
| Supplemental Security Income (SSI) | 80 | N/A | N/A |
| TEFRA/Katie Beckett | 57 | DCEP | DHHS Form 3290, TEFRA Application ORDHHS Form 3400 and DHHS Form 3400-A |
| Waiver Services (WS) -No SSI | 15 | Local eligibility worker | DHHS Form 3401ORDHHS Form 3400 AND DHHS Form 3400-B |
| Home and Community Based Services for SSI recipient (SSI-WS) | 80 | N/A | N/A |
| Working Disabled (WD) | 40 | Local eligibility worker | DHHS Form 3400 and DHHS Form 3400-A |
| Former Foster Care (FFC) | 61 | Local eligibility worker | DHHS Form 3400 |

**Qualifying Categories for Medicaid**

Qualifying Category (QCAT) is the categorical eligibility criteria under which the Applicant/Beneficiary is applying for or receiving assistance. This field is completed on ELD00 in MEDS.

| **Q-CAT** | **Allowable Payment Category** | **Beneficiaries** |
| --- | --- | --- |
| 10 | 10, 14, 15, 16, 32, 33, 54, 80, 85, 86, 90 | Aged (Over age 65) |
| 20 | 10, 14, 15, 16, 19, 32, 33, 40, 54, 57, 80, 81, 85, 86, 90 | Blind |
| 30 | 11, 12, 30, 55, 59, 87, 88, 91 | FI-Related Groups |
| 31 | 31, 51 | IV-E Foster Care |
| 50 | 10, 14, 15, 16, 17, 18, 19, 20, 32, 33, 40, 50, 54, 56, 57, 71, 80, 81, 85, 86, 90 | Disabled (Under age 65) |
| 60 | 13, 60 | Regular Foster Care |
| 70 | 70 | Refugee/Entrant |

Applicants assessed for Medicaid eligibility are assessed utilizing either MAGI or Non-MAGI methodology, depending on the Payment Category for which they are applying.

| **Medicaid Categories** |
| --- |
| **MAGI** |
| **PCAT** | **Category** |
| 11 | Transitional Medicaid |
| 12 | Deemed Infants (Infants up to Age 1) |
| 13 | Special Needs/Subsidized Adoption |
| 31 | Title IV-E Foster Care |
| 51 | Title IV-E Adoption |
| 55 | Family Planning |
| 59 | Parent/Caretaker Relative  |
| 60 | Regular Foster Care |
| 61 | Former Foster Care |
| 87 | Pregnant Women |
| 88 | Partners for Healthy Children |

| **Non-MAGI** |
| --- |
| **PCAT** | **Category** |
| 16 | 1977 Pass Along |
| 17 | Early Widows/Widowers |
| 18 | Disabled Widows/Widowers |
| 19 | Disabled Adult Children |
| 20 | Pass Along Children |
| 32 | ABD |
| 40 | Working Disabled |
| 48 | Qualifying Individual |
| 50 | Qualified Disabled and Working Individual |
| 52 | SLMB |
| 80 | SSI |
| 81 | SSI with Essential Spouse |
| 90 | Qualified Medicare Beneficiaries |

|  |
| --- |
| **INSTITUTIONAL** |
| **PCAT** | **Category** |
| 10 | MAO – Nursing Home |
| 14 | MAO – General Hospital |
| 15 | MAO – Other |
| 33 | ABD - Nursing Home |
| 54 | SSI Nursing Home Beneficiaries |
| 85 | OSS Only |
| 86 | OSS with SSI |

|  |
| --- |
| **SPECIALTY** |
| **PCAT** | **Category** |
| 57 | TEFRA |
| 70 | Refugee Assistance |
| 71 | Breast and Cervical Cancer |

**101.03.03 Applying Without Delay**

(Rev. 09/01/14)

CFR [§435.907](http://www.ecfr.gov/cgi-bin/text-idx?SID=1b4fd0b5e9cdf2a1c8958e150774f5c3&node=42:4.0.1.1.6.10.72.8&rgn=div8); [CFR §435.912](http://www.ecfr.gov/cgi-bin/text-idx?SID=1b4fd0b5e9cdf2a1c8958e150774f5c3&node=42:4.0.1.1.6.10.73.13&rgn=div8)

An application must be taken immediately for any person expressing a desire to apply. A clearly ineligible person may file an application that must be accepted and then denied.

The person must be allowed to complete the application while in the office. An application is considered complete when it has enough information to determine eligibility.

* The date the signed application is received must be documented.
* For paper applications, the Application Date is the date the application is received and must be documented on the first page of the application.
* All paper applications must be scanned into OnBase within three (3) business days of its receipt.
* All applications must be entered into Cúram or MEDS as appropriate within five (5) days of receipt.
* A face-to-face interview is not required; however, if an application filed online, in person, or by mail is not complete, the Eligibility Worker must contact the applicant within five (5) business days from the date of the request to obtain the required information. The Eligibility Worker can require a telephone or personal interview in order to obtain the information necessary to complete the eligibility determination. However, if the contact is by mail, the Eligibility Worker must retain the original application and mail a copy to the applicant requesting the missing information. The applicant cannot be required to complete another application form.
* If an applicant calls SC DHHS to request an application, the effective date of the application is the date on which the signed and dated application is received, NOT the date of the phone call.
* For applications completed by telephone, the date of application is the date the telephonic signature is captured.
* An unsigned application should never be discarded. If an unsigned application is received, it should be returned to the Applicant with an explanation that it must be signed. No further action is required since an application is not valid until signed.
* The date a faxed application is received by the agency is considered the date of application.
* The date an online application is electronically signed and submitted to the agency is considered the date of application.
* Regardless of when the application is entered into the MEDS/Cúram computer system, the date of application is the date the signed application was received, whether complete or incomplete.
* If an applicant needs to return any other information needed to make a decision, a written list must be sent to the applicant.
	+ The written list must give the Applicant a deadline to return the information.
	+ For applications submitted through the Healthy Connections Citizen Portal or the Health Information Marketplace, the Applicant may receive a list of unverified information, such as identity or income. This is provided on a PDF copy of the application generated by Cúram. The Eligibility Worker will utilize current verification policies to verify this and any other financial and non-financial information needed to determine eligibility.
	+ The [SC DHHS Form 1233 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, should be used to request additional information for an application to be completed.
	+ The request must be mailed or given to the Applicant by the end of the business day following the day the completed application is received.

**101.03.04 Signature Requirements**

(Eff. 06/01/14)

A Medicaid application must contain a valid signature to be processed. Signature requirements vary based on whether the individual seeking services is an adult or a minor.

**101.03.04A Applicants Age 18 or Older**

(Eff. 04/01/18)

**Who May Sign the Application**

The following persons may sign the application provided the relevant criteria are met.

The Applicant

An adult Applicant who has the mental capacity to legally conduct his own affairs may sign and submit his own application for Medicaid coverage.

A Household Member

A household member may sign and submit an application on behalf of himself, his spouse, and any family members living in his household. The person completing the application will be considered the Primary Individual (See SC MPPM [101.02.09](#MPPM_101_02_09)).

**Example**

An individual may submit an application on behalf of himself and his sibling who lives with him.

A Third Person

Someone other than the Applicant may submit an application on the Applicant’s behalf if he acts with the Applicant’s knowledge and consent (See SC MPPM [101.02.10](#MPPM_101_02_10)).

**NOTE**

If a Legal Representative has been appointed to act on the Applicant’s behalf that Legal Representative stands in the shoes of the Applicant. To submit an application, a Third-Party Applicant must act with the Legal Representative’s knowledge and consent.

If an application is submitted without the Applicant’s knowledge and consent, the Medicaid office must advise the Third-Party Applicant that the agency cannot take action until such knowledge and consent is obtained.

**Example**

An adult daughter may submit an application on behalf of her elderly mother, who lives in a separate household, if her mother knows about and consents to the daughter applying for her.

**NOTE:**

A Form 1282 is NOT required for a Third-Party Applicant to submit an application on an adult Applicant’s behalf. However, that Third Party Applicant will have NO right to manage the Applicant’s case unless he is (i) the Applicant’s spouse, (ii) appointed Authorized Representative by the Applicant via the Form 1282, or (iii) the court grants/approves legal authority.

**Methods of Signing**

Paper Application

If the Applicant is submitting a paper application, the application is considered complete when the Applicant or his authorized party signs it.

If the Applicant is physically unable to write his or her name (i.e., he does not know how to read or write), he may sign with an “X”. Two witnesses must also sign the application verifying the mark is intended to serve as the Applicant’s signature.

**NOTE**

An applicant who does not know how to write is treated differently than an applicant who is legally declared mentally incapacitated or incompetent.

Telephonic Application

A telephonic signature is valid if submitted through an approved source. As part of the telephone application process the person assisting the Applicant must read him the Rights and Responsibilities associated with the application, and the Applicant must acknowledge his understanding. A recording will capture the Applicant’s permission to submit the application and his acceptance of the Rights and Responsibilities.

Effective April 1, 2018, telephone applications will be primarily received by the Member Services Contact Center. The applicant’s signature will be documented on the application by the Contact Center Agent as demonstrated below. The audio file will not be uploaded into OnBase but will be archived by the Contact Center.

|  |
| --- |
|  |

A telephone application may also be conducted through contact with SCThrive. The PDF and a copy of the audio file will be loaded into OnBase.

Electronic Application

An electronic signature is valid for applications submitted through an approved online source, such as the Healthy Connections Citizen Portal or SCThrive. If an applicant applies online, he will be asked to type his name into the application field. This act will serve as his electronic signature.

The Worker Portal

The Worker Portal is used in the following instances:

* When an applicant submits an application in a walk-in interview,
* When a paper application is entered by a worker,
* When a telephone application is received by the Member Services Contact Center, and
* When SCThrive sends a PDF application and audio file to Central Mail.

After an applicant completes an application during an interview in a county office, the worker will give the applicant a printed copy of the DHHS Form 3403, Rights and Responsibilities, to sign. A Medicaid application must contain a valid signature to be processed. The worker will scan the form into OnBase with the rest of the application. The applicant’s signature on the Rights and Responsibilities Form is not needed if the applicant’s signature is already on file.

**Authorized Representative**

An Authorized Representative (see MPPM [101.02.02](#MPPM_101_02_02)) designated in a written statement may sign the application on the Applicant’s behalf.

**No Individual Authorized to Sign**

If the applicant lacks legal capacity such that he cannot sign the application himself (i.e. the applicant is legally incompetent or incapacitated) and does not have an Authorized Representative or Legal Representative the application may not proceed until such a responsible party is obtained.

When the Applicant is a long term care resident, Eligibility Workers should coordinate with the facility and/or the Ombudsman’s office to identify and secure a legal representative.

The State Long Term Care Ombudsman’s Office may be reached by calling 1-800-868-9095.

**Pending Individual Authorized to Sign**

If the applicant lacks legal capacity such that he cannot sign the application himself (i.e. the applicant is legally incompetent or incapacitated) and does not have an Authorized Representative or Legal Representative, the application may proceed IF the procedures have been initiated to legally appoint a Legal Representative. Eligibility Workers should complete as much of the application process as possible based on the information available then pend the case in MEDS/Cúram until the court appoints a representative.

**Procedure for Determining Who Can Sign the Application**

|  |
| --- |
| **Procedure for Determining Who Can Sign the Application** |
| Before processing an application for Medicaid, the Eligibility Worker should determine if a proper signature is included. If the application is signed by someone other than the Applicant or if one application is submitted on behalf of numerous individuals, determine the following: If submitted by a person: 1. Are any adults included in the application other than the Primary Individual’s spouse?
	* If yes, continue to question 2.
	* If no, the signature is proper.
2. Does the adult Applicant have a court appointed Legal Representative, such as a Guardian or holder of Power of Attorney, who is required to sign this application on that Applicant’s behalf?
	* If yes, continue to question 3.
	* If no, continue to question 4.
3. Is the Primary Individual the legally appointed representative acting on the Applicant’s behalf?
	* If yes, accept signature as proper.
	* If no, there is no proper signature. The application cannot be processed until a valid representative signs it.
4. Does the Applicant know that you are submitting this application and does he consent to it?
	* If yes, the signature is proper.
	* If no, there is no proper signature. The application cannot be processed until consent is obtained.

If submitted by an institution, entity, or organization (Ex. A nursing home) 1. Does the Applicant have the legal capacity to submit his own application?
	* If yes, continue to question 4.
	* If no, continue to question 2.
2. Does the Applicant have a court appointed Legal Representative, such as a Guardian or holder of Power of Attorney, who is required to sign this application on that Applicant’s behalf?
	* If yes, continue to question 3.
	* If no, see SC MPPM [101.03.04A](#MPPM_101_03_04A) sections “No Individual Authorized to Sign” and “Pending Individual Authorized to Sign”.
3. Is the organization submitting the application the legally appointed representative acting on the Applicant’s behalf?
	* If yes, accept signature as proper.
	* If no, there is no proper signature. The application cannot be processed until a valid representative signs it.
4. Does the Applicant know that the organization is submitting this application and does he consent to it?
	* If yes, the signature is proper.
	* If no, there is no proper signature. The application cannot be processed until consent is obtained.
 |

**101.03.04B Applicants Under Age 18**

(Eff. 06/01/14)

When an applicant is under age 18, a parent, legal guardian, or, if the child is in DSS’ custody, a DSS worker may submit an application on the child’s behalf. Alternatively, a minor is legally able to sign his own Medicaid application if he is (1) legally emancipated from his parents; (2) no longer under the care and control of his parents, legal guardian, or caretaker relative who would normally file for benefits on his behalf; or (3) applying for Family Planning or Pregnant Woman coverage.

NOTE: A minor whose parents’ claim her as a tax-dependent may only apply for Pregnant Woman coverage independently of her family **IF she is able to provide her complete household income information**. MAGI requires the income of every household member to be counted, and selective income disregards can no longer be applied to Pregnant Woman eligibility. Any reported income that is not reasonably compatible with electronic sources will need to be verified with additional sources.

**Minor Parent Applying for His Child**

A parent under age 18 may apply for Medicaid for his own child because he is the parent of the child.

**Enrollee Turns 18**

When a child who is enrolled in Medicaid turns 18, it is not necessary to obtain a new application signed by the enrollee.

When a child who is enrolled in Medicaid turns 19, the child must apply as an adult.

**101.03.04C Unsigned Applications**

(Eff. 06/01/14)

An unsigned application should never be discarded. If an unsigned application is received, it should be returned to the applicant with an explanation that it must be signed. No further action is required since an application is not valid until signed.

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**101.03.05 Processing Applications**

(Rev. 12/01/21)

[CFR §435.912](http://www.ecfr.gov/cgi-bin/text-idx?SID=1b4fd0b5e9cdf2a1c8958e150774f5c3&node=42:4.0.1.1.6.10.73.13&rgn=div8)

Applications are accepted and processed by the South Carolina Department of Health and Human Services (DHHS).

* The Specialty Unit in Richland County processes applications for the TEFRA and Breast and Cervical Cancer (BCCP) programs. Applications received by LEP staff should be scanned into OnBase. Scan applications to be processed in MEDS using Document Type “MEDS Application” and Claim Type “BCCP/TEFRA”. Scan applications to be processed in Cúram using Document Type “MEDS-Cúram Application” and Claim Type “CGIS BCCP/TEFRA”.
* The Local Eligibility Processing (LEP) and the Processing Centers processes all other FI (MAGI) and SSI (Non-MAGI) related programs. Refer to [MPPM 101.03.06](#MPPM_101_03_06) for instructions concerning applications of SC DHHS employees and immediate family members.

Note: An initial budget based on the applicant's self-reported income, pregnancy, citizenship, and family circumstances must be completed on the day an application is received to determine eligibility for Pregnant Women. If the Eligibility Worker cannot process the application the date it is received, (i) a decision must be made by the end of the next business day and (ii) the reason the application could not be processed must be documented in the case record. It is important that the pregnant woman has coverage to access prenatal care as quickly as possible. Refer to SC MPPM 204.02 for specific instructions on processing Pregnant Women applications.

* Department of Disabilities and Special Needs (DDSN) sponsored eligibility workers are located in the DDSN regional offices. These eligibility workers are responsible for processing Medicaid applications for the following groups:
	+ Institutionalized individuals who must meet the Intermediate Care Facility/Intellectual Disabilities (ICF/ID) level of care to qualify for Medicaid coverage of the cost of care in the facility;
	+ Individuals applying for waivered services under the Intellectual Disabilities and Related Disabilities (ID/RD) Waiver; and
	+ Persons applying for waivered services under the Head and Spinal Cord Injury (HASCI) Waiver.
	+ An application taken by the county or Local Eligibility Processing office for services through the ID/RD waiver should be forwarded with available verifications to the DDSN sponsored eligibility worker for processing. The application must not be held for the return of additional information.
	+ An application taken by the county or Local Eligibility Processing office for services through the HASCI waiver should be forwarded with available verifications to the DDSN sponsored eligibility worker for processing. The application must not be held for the return of additional information.

**101.03.05A Procedure for MAGI, Non-MAGI, and Blended Household Cases – Online Applications**

(Eff. 11/01//14)

When applications have been submitted to the agency through the FFM’s Citizen Portal, the eligibility worker must take the following steps to determine eligibility.

| **Procedure for MAGI, Non-MAGI, and Blended Household Cases** |
| --- |
| **MAGI Household** | 1. The applicant applies online.
2. Cúram will conduct a preliminary determination. If all people are categorically eligible for MAGI with no indication of disability, need for long term care, or age 65, the application will be processed in Cúram.
3. If all members are not categorically eligible for MAGI and there is an indication of disability, need for long term care, or anyone over age 65, the worker determines if the application is a non-MAGI household or a blended household.
 |
| **Non-MAGI Household** | 1. For an application with all non-MAGI applicants:
2. The application will enter the Cúram indexing queue.
3. The eligibility worker will re-index the application as a MEDS Application in OnBase.
4. An eligibility worker will enter the application data into MEDS.
5. The eligibility worker sends the appropriate addendum and the Healthy Connections Checklist, DHHS FM 1233, for the non-MAGI determination.
6. The eligibility worker sends the tracking form to the MEDS follow up queue.
 |
| **Blended Household**  | 1. A blended household includes members of the household that are MAGI and non-MAGI eligible. For an application with a blended household:
2. Cúram will complete the eligibility determination for the MAGI categories and forward their information to the FFM, if necessary.
3. The application will enter the Cúram indexing queue.
4. An eligibility worker will pull the application from the Cúram indexing queue and check Cúram to determine if the MAGI determination has been completed. If it has not been completed, the worker will send FM 1233 with the necessary information required to complete a determination.
5. The eligibility worker will create a duplicate tracking form, and send the original tracking form to the MEDS follow up queue.
6. The duplicate tracking form will enter the MEDS Intake queue where another eligibility worker will process it.
7. The eligibility worker will enter the application data into MEDS. This includes entering the MAGI eligible members as non-applying members in the *non-MAGI* *household*.
8. The eligibility worker sends an addendum and FM 1233 for the non-MAGI determination.
9. The eligibility worker sends the tracking form to the MEDS follow up queue.
10. When verifications are returned, the worker must take the following steps:
11. Complete the determination in MEDS.
12. If the applicant is eligible for full coverage in MEDS, the worker closes the case in Cúram.
13. The worker enters a Service Manager ticket to have the Cúram coverage wiped out, so there is no reconciliation issue with coverage overlap in MEDS and Cúram.
14. The Service Manager ticket will be routed to the Cúram Help Desk.
15. Customer Service will update the eligibility screen in Cúram.
16. Before the screen update is in production, Customer Service will submit a Tiger Tracks ticket to have database updated.
17. The worker must add a case note to the Insurance Affordability Case in Cúram.
 |

**101.03.05B Procedure for MAGI, Non-MAGI, and Blended Household Cases – Paper Applications**

(Eff. 11/01//14)

When applications have been submitted via paper application, the following steps must be taken to determine eligibility.

|  |
| --- |
| **Procedure for Blended Household Cases** |
| **MAGI Household** | 1. The applicant applies with a paper application.
2. The application is scanned in OnBase. Once the application is received by the eligibility worker, the worker reviews the application to determine if it requires a MAGI, non-MAGI, or blended household analysis.
3. The application will be processed in Cúram unless the application is FM 3401. The eligibility worker must follow the standard process to register the primary applicant, enter the application into Cúram, and submit the application.
4. If the eligibility worker is able to complete a MAGI determination (there are no outstanding verifications), the eligibility worker authorizes the application case in Cúram.
5. If the eligibility worker is not able to complete the MAGI determination, the worker must send FM 1233 to the applicant.
6. The eligibility worker creates a duplicate tracking form.
7. The original tracking form will enter the MEDS follow up queue.
8. The duplicate tracking form will enter the MEDS Intake queue where it will be processed by another eligibility worker.
9. The eligibility worker will enter the application data into MEDS. This includes entering the MAGI eligible, and potentially MAGI eligible members, as non-applying members in the *non-MAGI household.*
 |
| **Non-MAGI Household** | 1. The eligibility worker sends the appropriate addendums and FM 1233 for the non-MAGI determination to the applicant.
2. The eligibility worker sends the tracking form to the MEDS follow up queue.
3. When verifications are returned, the worker must take the following steps:
4. Complete the determination in MEDS.
5. If the applicant is eligible for full coverage in MEDS, the worker closes the case in Cúram.
6. The worker enters a Service Manager ticket to have the Cúram coverage deleted, so there is no reconciliation issue with coverage overlap in MEDS and Cúram.
7. The Service Manager ticket will be routed to the Cúram Help Desk.
8. Customer Service will update the eligibility screen in Cúram.
9. Before the screen update is in production, Customer Service will submit a Tiger Tracks ticket to have database updated.
10. The worker copies the notice to OnBase, and adds a case note to the Insurance Affordability Case in Cúram.
 |

**101.03.06 Processing Applications of DHHS Employees and Family Members**

(Rev. 12/01/19)

Regarding his own application for Medicaid benefits, a SC DHHS employee must not:

* Process, re-determine, re-budget, or make changes to his application;
* Edit his case information in OnBase, MEDS, or Cúram;
* Directly add, remove, replace, or edit documents or verification in the case record; OR
* Scan any additional information into OnBase.

Regarding the application of an immediate family member or household member, a SC DHHS employee must not:

* Process or maintain the case;
* Edit information in OnBase, MEDS, or Cúram;
* Directly add, remove, replace, or edit documents or verification in the case record; OR
* Scan any additional information into OnBase.

An “immediate family member” includes the employee’s spouse, children, parents, siblings, grandparents, grandchildren, in-laws, and legal guardians.

If an employee is aware that any other family member will apply to receive Medicaid benefits, he/she must discuss the situation with the immediate supervisor. The supervisor will determine the proper course of action for handling the case.

Depending on the circumstances of the application, the supervisor may determine one of the following:

* No special treatment of the case is required, and another Eligibility Worker may pick up the case in normal workflow;
* The case must be processed and maintained by another employee outside of the county office;
* The case must be processed by the supervisor or their designee; or
* Another course of action is necessary.

The supervisor must document in the case record the decision and the reasoning for the specific course of action recommended.

| **Procedure for Processing Applications of SC DHHS Employees, Members of their Household or Immediate Family Members:** |
| --- |
| Any application or active case in any local eligibility office must be processed using the following procedures. * When the application is made in person, a supervisor or the Eligibility Worker appointed by the supervisor must provide intake. The supervisor, or his designee, is responsible for generation a [SC DHHS Form 1233 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf) to request any additional information needed to determine eligibility.

**MEDS Procedure**Non-MAGI and MAGI applications must be pended in MEDS by the supervisor or appointed Eligibility Worker **Cúram Procedure**MAGI applications should be entered into Cúram by the supervisor or appointed eligibility worker. **OnBase Procedure**When an Eligibility Worker is assigned his own or a family member’s application, he should document the Tracking Form and send it to the Supervisor Queue. Once the application has been sent to the Supervisor Queue, the Supervisor will review the case and make a determination on how it should be processed. If the Supervisor determines that the case should be assigned to another Eligibility Worker (rather than the Supervisor processing it himself), the Supervisor will specifically assign an Eligibility Worker to process the application, document the Tracking Form, and send the application back to the Assessment/Processing Queue for that worker to retrieve and process.  |

**101.03.07 SC DHHS Employees Conflict of Interest**

(Rev. 01/01/14)

SC DHHS employees must never directly or indirectly request that another SC DHHS employee process an application for themselves, family members, or friends. An application for a SC DHHS employee, family members, or friends must be discussed with his or her immediate supervisor and/or Regional Administrator to avoid a conflict of interest. Applications for an employee or immediate family members must be handled according to the policy in MPPM [101.03.06](#MPPM_101_03_06). An application for the friend of an agency employee must be assigned by the supervisor or Regional Administrator. SC DHHS employees must not review, research or change information in MEDS, Cúram, or OnBase related to a member of their household or immediate family. SC DHHS employees must not review, research, or change information in MEDS, Cúram, or OnBase related to friends of an employee unless the case has been assigned to the employee by the supervisor or Regional Administrator.

**101.03.08 Informing the Applicant**

(Eff. 11/01/14)

Should an application interview be needed, the interview (which may be conducted by telephone or in person) must include at a minimum the following explanations:

* The eligibility requirements, the agency's standard of promptness, the right to a fair hearing, the procedure for requesting a hearing, rights under Title VI of the Civil Rights Act of 1964, and rights under Title V and Section 504 of the Rehabilitation Act of 1973;

Note:The Rights and Responsibilities of SC Healthy Connections Medicaid Applicants and Beneficiaries brochure must be given to the applicant/authorized representative. This brochure replaces the individual Civil Rights Pamphlet and Fair Hearing and Appeals Brochure. MEDS/Cúram can be updated to document that the brochures have been given to the applicant/authorized representative;

* The responsibility of the applicant to give complete and accurate information, to report any changes in circumstances and penalties for providing false information (Refer to MPPM [101.12](#MPPM_101_12) for a complete discussion of these Rights and Responsibilities.);
* An explanation of the methods of establishing eligibility, including the need for making collateral contacts and the use of documentary and other records for verifying pertinent information, including the use of computer matches (such as BENDEX, IEVS) to verify the presence of income of family members;
* The services covered by Medicaid, including instructions on the appropriate use of the Medicaid insurance card;
* The third-party liability process, including the responsibility to cooperate in obtaining medical support;
* The services available through the Women, Infants, and Children (WIC) program at the county health department. Where appropriate, the applicant must be referred to the WIC program;
* The estate recovery program, when appropriate. (Refer to MPPM 304.27, Nursing Home, Waiver Services, General Hospital.);
* The services available to children under age 21 through the Early, Periodic Screening, Diagnosis and Treatment program (EPSDT).

**101.03.09 Request for Informal Medicaid Eligibility Opinion**

(Renum. 01/01/09; Eff. 01/01/07)

Individuals seeking assistance from other social service agencies may be required to obtain a statement from SC DHHS indicating he/she is not eligible for Medicaid. If the individual indicates through questioning that none of the categorical eligibility requirements would be met, the Eligibility Worker may complete a [DHHS Form 3300](http://medsweb.scdhhs.gov/EligibilityForms/FM%203300.pdf), Informal Medicaid Eligibility Opinion, to give to the individual. It must be explained that the decision is not an official denial, and it cannot be appealed. If a proper denial letter is required, an application must be filed, and a decision rendered after all eligibility factors have been examined according to Medicaid policy. The DHHS Form 3300 cannot be used to indicate a person’s ineligibility due to financial or other non-categorical eligibility criteria.

**101.03.10 Account Transfer Applications**

(Eff. 06/01/14)

Individuals may apply for state Medicaid coverage through the Federal Facilitated Marketplace (FFM). An Application received from the FFM is referred to as an Account Transfer Application (ATA). ATAs are delivered from the FFM to the state in which the applicant resides as a PDF.

**101.03.10A Effective Date**

(Eff. 06/01/14)

ATAs submitted prior to January 1, 2014, will have an Application Effective Date (AED) of January 1, 2014. ATAs submitted on or after January 1, 2014, will have an AED of the date of the application. Refer to the chart below for the correct AED based on date of application.

|  |  |
| --- | --- |
| If the Applicant applied… | Then the Application Effective Date will be… |
| Between October 1 – December 31, 2013 | January 1, 2014 |
| On or After January 1, 2014 | the Date of Application |

*Example 1*: Charles submitted an application for his family on October 13, 2013. The AED on his application will be January 1, 2014, and coverage will begin January 1, 2014.

*Example 2*: A pregnant woman applied to the FFM on January 3, 2014. Before she receives an eligibility determination, she submits an additional application for Medicaid on February 10, 2014. Based on the February application, she was determined eligible in MEDS for Medicaid benefits beginning February 1, 2014. Later the PDF of her January ATA is received. Based on a review of the January ATA, it is determined that she is reasonably compatible for Pregnant Woman (PW). SCDHHS should change the AED to January 3, 2014.

**NOTE**: A Help Desk ticket is required to insert the eligibility dates in Example 2.

**101.03.10B Identifying ATA Household Member’s Current Eligibility or Application Status**

(Eff. 06/01/14)

The ATA is color-coded to assist the Eligibility Worker with quickly identifying each household member’s current eligibility or application status. Each household member’s “About Applicant” section is shaded one of the following colors:

* **Green** indicates the applicant is applying for coverage and not currently eligible for benefits in MEDS.
* **Blue** indicates the applicant is currently eligible for benefits in MEDS; however, the Eligibility Worker needs to determine if the individual was eligible for Medicaid in the month that he/she submitted the application to the FFM.
* **Pink** indicates the individual is a member of the household but is not seeking Medicaid benefits.

**101.03.10C Processing Account Transfer Applications**

(Rev. 11/01/18)

ATAs received from the FFM must be evaluated for both MAGI and Non-MAGI eligibility.

**A. Evaluate for MAGI Eligibility**

Workers should first determine if the individuals listed on an ATA are eligible under MAGI methodology.

* Income:

The application’s reasonable compatibility section determines if a named applicant is income eligible for Medicaid under a MAGI category. The result is based on whether the applicant’s self-attested income is reasonably compatible (RC) with the electronic data source’s reported income.

If only hourly income is provided on the application, in order to determine income, first attempt to contact the applicant by phone to determine the expected number of hours per week the applicant works, and how frequently the applicant is paid. If the applicant’s hours vary then ask for annual income and divide by 12. If the information cannot be obtained by phone contact, send the applicant a FM 1233 to obtain this information. Calculate income following procedures outlined in MPPM 203.04.01.

Note: The RC section does NOT take into account categorical eligibility. (i.e. an adult with no minor children in the home will be listed as income eligible for PCR even if they are not a parent or caretaker relative.)

* Pregnancy:

If a member of the household reports she is pregnant, assume that number of expected children is 1. However, if an additional expected-child will impact eligibility, contact the applicant to confirm the number of expected children.

|  |
| --- |
| **Procedure for Determining whether a Workbook is necessary.** |
| A Workbook **MAY NOT** be necessary to determine MAGI eligibility.The workbook is required if:* No reasonable compatible section is shown nor are results available.
* The household has a child who receives an earned income higher than the tax-filing threshold.

Note: If the child’s earned income exceeds the tax-filing threshold, his earned income and any Social Security income he receives are counted in the household income. The workbook is **NOT** required if:* Reasonable compatible and countable income is given.
* All applicants are over-income (in this case you are required to deny the case).
 |

**B. Evaluate for Non-MAGI Eligibility**

Next, review the application to determine if:

* + - Any applicant is over 65 years old, or indicates that he/she is blind and/or disabled.

If so, the Eligibility Worker should: complete a FM 1233; create a second tracking form in OnBase; and send the appropriate Non-MAGI addendum(s) and needed verifications to collect the necessary information to make a SSI-related determination.

* + - Any applicant indicates he may be eligible for long-term care services by stating he is living in a medical facility or institution or indicates that he has limited activities of daily living (ADL).

If so, apply the same steps as above.

**C. When do I need to send a 1233?**

The following table details when a Form 1233 should be sent.

| **Factor** | **Send 1233?** | **Instead:** |
| --- | --- | --- |
| Household composition is self-reported | NO | Accept the self-attestation |
| Income is verified on PDF with WAGE Match | NO | Accept DS reported on PDF. Person Composite Service (PCS) Wage Verification does not need to be used.  |
| Income data source not in PDF | NO | Check PCS Wage Verification |
| Income data source not in PDF OR available in Person Composite Service (PCS) Wage Verification | YES |  |
| Attested income over $300 and no data match. | YES |  |
| Attested income under $300, including zero income, and no data match | NO | Accept self-attestation |
| Income is only provided in hourly format | YES, if unable to contact the Applicant and determine the number of hours worked per week. |  |
| Citizenship is not verified | YES |  |
| SSN is not verified | YES |  |
| Quarters are not verified | YES, only if a required condition of eligibility  |  |
| The applicant is over 65 | YES, Send 3400A or 3400B, whichever is most applicable  |  |
| The applicant indicates disability | YES, Send 3400A |  |

**Note:** If no income is recorded, complete the unemployment workbook to identify if the individual needs to be referred to SCDEW for Unemployment Benefits. If referral is needed, complete the checklist and send to client. Regardless, complete the determination.

**D. Retroactive Coverage**

Retroactive coverage must be requested by the applicant. If an applicant indicated on the application that he has medical bills in any of the three months prior to the Application Effective Date (AED), the Eligibility Worker should first process current eligibility based on the AED. If retroactive coverage is requested outside of the ATA, follow the policy and procedures below.

|  |
| --- |
| **Procedure for Processing Retroactive Coverage** |
| If an applicant is eligible for retroactive benefits, the Eligibility Worker should mail FM 3400-C, Request for Retroactive Coverage, to the applicant.An applicant may also request Retroactive Coverage by phone or in person. For requests by phone or in person, the Eligibility Worker is to ask the applicant for their monthly income and verify electronically while the person is present or on the phone if possible. Request documentation only if electronic verifications are not available. Follow current income verification policies and procedures (MPPM Section 203).For Retroactive Coverage requests received by mail, attempt to verify income electronically. Request documentation only if necessary.If MEDS will not allow the Eligibility Worker to approve the month(s) requested, then a Help Desk ticket is required to insert the eligibility dates. |

The Eligibility Worker should not hold up the eligibility determination of benefits from the application date. If able to approve or deny the application, the eligibility worker should take that action, and then process eligibility for the retroactive months.

**101.04 Retroactive Applications**

(Rev. 09/01/17)

The agency may authorize Medicaid for any or all of the three (3) calendar months preceding the month of application for medical assistance. An applicant may be eligible for retroactive coverage even though the application for current or continuing medical benefits is denied. A separate application is not required for retroactive benefits unless the application is made posthumously. Retroactive eligibility will only be considered after a full application has been submitted. A request for a retroactive decision can be made at any time by the following means:

1. An indication on the application
2. Filing a DHHS Form 3400-C, Request for Retroactive Medicaid Coverage
	1. A DHHS Form 3400-C can be submitted if the individual did not indicate on the application that retroactive coverage is requested and now wants a retroactive determination
	2. A DHHS Form 3400-C can be submitted if an individual requested retroactive coverage on an application, but a decision was not made by the agency at the time of approval or denial
	3. The DHHS Form 3400-C can be completed by agency or call center staff when a retroactive request is made by phone OR by the applicant/ beneficiary

**Note:** A DHHS Form 3400-C should be scanned into OnBase as MEDS-Retro Request. The request will either be added to an Active Tracking Form or a Tracking Form will be created and go into the Change Queue

The following requirements must be met after retroactive Medicaid is explained to the applicant:

* Retroactive coverage must be explored if the individual self-reports that he/she has outstanding medical expenses and requests that eligibility be determined for Medicaid benefits.
* It must be established that the individual met all financial and categorical criteria in each of the retroactive month(s) for which Medicaid eligibility is requested. Eligibility is also determined based on the individual’s actual financial circumstances for each of the retroactive months in question.
* When the individual’s categorical eligibility is based on the factors of blindness or disability, blindness or disability must be established and/or verified for the retroactive period.

If the above requirements are met, the individual may be found eligible for Medicaid for any or all of the retroactive months. The eligibility decision must be made independently for each of the three (3) months and documented in the case file.

Use the following table for MAGI retroactive determinations.

| **Income** | **Household****Composition** | **Action** |
| --- | --- | --- |
| Same | Same | Budget application month income for each Retroactive month |
| Same | Different | Contact applicant for details |
| Same | Not shown | Budget application month income for each Retroactive monthAssume same Household Composition |
| Different | Same | Budget the reported income for each retroactive monthCheck electronic data sources if available |
| Different | Different | Contact applicant for detailsCheck electronic data sources if available for income |
| Different | Not shown | Budget reported income for each Retroactive monthCheck electronic data sources if availableAssume same Household Composition |
| Not shown | Not shown | Contact applicant for details |

Income and Resources must be verified for each retroactive month for non-MAGI/SSI-Related categories

**Reminder:** If eligibility can be established for application month but the necessary information to make a retroactive decision is missing, complete the eligibility decision and request the missing information. If unable to obtain through a phone call, send a DHHS Form 1233 and place the case in follow-up.

|  |
| --- |
| **Procedure For Retroactive Decisions Made After The Initial Medicaid Determination** |
| **MEDS Procedure** 1. MEDS does not generate a notice for a retroactive determination made after the initial Medicaid eligibility decision.The Eligibility Worker must notify the applicant/beneficiary using the [DHHS Form 3229-D](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229-D.pdf), Notice of Approval/Denial for Retroactive Medicaid Benefits.
2. The eligibility worker must also provide [DHHS Form 945](http://medsweb.scdhhs.gov/EligibilityForms/FM%20945.pdf), Verification of Medicaid, for retroactive decisions made after the initial Medicaid determination for dates of service outside of the one year timely filing period. The User ID identifying the worker completing the form must be included on the DHHS Form 945.

**Note the Following**1. Medicaid policy requires that only “clean” claims received and entered into the claims processing system within one year from the date of service be considered for payment. A “clean” claim is free of errors and can be processed without obtaining additional information from the provider or another third party.
2. [DHHS Form 945](http://medsweb.scdhhs.gov/EligibilityForms/FM%20945.pdf) is also used for other requests to verify Medicaid eligibility.
3. Specific instructions regarding retroactive coverage for OCWI-Pregnant Woman cases are found in MPPM 204.02.01D.
4. In some situations, the individual may be found eligible for Medicaid benefits, but not for a vendor payment because certain Medicaid requirements specific to long-term care were not met.
5. If the individual was a resident in another state throughout one of the months in the retroactive period, he/she must apply for benefits in that state. (Refer to MPPM 102.03.09)
 |
| **Procedure For Updating Retroactive Coverage**  |
| **MEDS Procedure**(Do not change the Begin Date set by the system after performing *Make Decision* in MEDS)**MEDELDOO** Go to the top of the screen to change the date to the retroactive coverage month needed.DATES-FROM: MM / YYYY THRU: 00 / 0000**MEDELDO1** Complete the screen by entering the countable Budget Group members, countable income and other information pertinent to the payment category. Do not update the “Next Review Date”.**MEDELD02** MEDS will display an ELD02 screen for each member included in the Budget Group. The eligibility *Begin* and *End* dates for that retroactive month will display.**Note:** If the *Medical Services in the Last 3 Months* indicator on the HMS06, Household Member Detail screen in MEDS was set to N when the application was locked, the retroactive budget months will not be found. A Service Manager ticket must be submitted. |
| **Cúram Procedure** The appropriate procedure may be found in the [Processing Retroactive Medicaid](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Processing%20Retroactive%20Medicaid.pdf?csf=1&web=1&e=g4J9gB) job aid at the [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/). |

**101.04.01 Appeal Rights**

(Eff. 01/01/14)

An applicant/ beneficiary or his authorized representative may request an appeal within thirty (30) calendar days from the date on a Notice of Adverse Action. The eligibility worker must follow the policy and procedures listed in [MPPM 101.12.11](#MPPM_101_12_10), Right to Appeal and Fair Hearing when a request to appeal a retroactive determination is received.

**101.04.02 Claims for Retroactive Eligibility**

(Rev. 12/01/15)

Medicaid policy requires that only “clean” claims received and entered into the claims processing system within one year from the date of service be considered for payment. A “clean” claim is free of errors and can be processed without obtaining additional information from the provider or another third party. Claims involving retroactive eligibility for dates of service that are outside of the one-year timely filing period must meet both of the following criteria to be considered for payment:

1. Be received and entered into the claims processing system within six (6) months of the beneficiary’s eligibility being added to the Medicaid eligibility system; **AND**
2. Be received within three (3) years from the date of service or date of discharge. Claims for dates of service that are more than three (3) years old will not be considered for payment.

When the individual’s eligibility is to be established based on the factors of blindness or disability, the individual’s blindness or disability must be established for the retroactive period, if not already established.

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**101.05 Posthumous Applications**

(Eff. 01/01/14)

An application for Medicaid may be made on behalf of a deceased person. An application for retroactive coverage can also be filed on behalf of a deceased person and must be filed before the end of the third month following the date of death.

Death is not an appropriate reason to deny an application for Medicaid benefits **unless** the applicant has no outstanding medical expenses subject to payment by Medicaid in the eligibility period surrounding his application.

When the applicant has incurred medical expenses before death, a full eligibility determination must be made.

**101.06 Access to the Application Process**

(Eff. 01/01/14)

Each application intake site is required to provide services to the limited English proficient, deaf, blind, or disabled applicant to comply with non-discrimination mandates under the Civil Rights Act and the Americans with Disabilities Act.

**101.06.01 Interpreters**

(Rev. 03/01/19)

Applicants/beneficiaries who are limited English proficient, deaf, or blind must be provided with an interpreter to eliminate barriers to applying for services offered under the Medicaid program.

The Eligibility Worker must arrange for auxiliary services such as an interpreter of a person’s native language, sign language, teletypewriter, telecommunication device for the deaf, telebrailles, visual or tactile signaling devices and assisted listening devices for the blind.

If the Eligibility Worker determines that a language interpreter is needed, he/she must access Telelanguage, Inc. (Refer to MPPM Chapter 802, Appendix B.) With supervisory approval, the Eligibility Worker should contact an interpreter and arrange for the service.

For applicants/beneficiaries requiring hearing or vision interpretive services, submit a ticket through Service Manager to make a request for assistance.

The agency has the Healthy Connections application and various other forms available in Braille. If an applicant makes a request for a Braille application, they can contact the Healthy Connections Member Services Center at 1-888-549-0820. This request will be forwarded to the appropriate local eligibility office to send what the requested form(s). The date of application will be the date the individual makes the request for the application from the Member Services Center.

Many application forms and addendums, as well as other supplementary forms, such as DHHS Form 1233, are available in Spanish. To view or print a Spanish language form, visit the [Medicaid Eligibility Forms](http://medsweb.scdhhs.gov/formslisting.htm) page.

**101.06.02 Request for Document Translation Services**

(Eff. 09/01/17)

Spanish version applications may not require translation services if a worker is able to clearly determine the answer to the question by comparing the English version of the application with the Spanish version. There is no difference in the meanings of the questions on the two applications. If the answer to a question cannot be clearly determined, translation services must be requested.

|  |  |
| --- | --- |
| Graphical user interface, application, email  Description automatically generated | Graphical user interface, application, Word  Description automatically generated |

When an application or other document requires translation, a request must be made through Service Manager as illustrated below:

|  |  |
| --- | --- |
| Graphical user interface, text, application, email  Description automatically generated | Graphical user interface, text, application  Description automatically generated |

**101.06.03 Barriers**

(Eff. 01/01/14)

Access to the facility should not be a barrier. Each facility where Medicaid eligibility workers are located should have access for handicapped persons. Elimination of barriers may be accomplished by sending eligibility workers to interview the person in his home or at a barrier-free alternative site.

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**101.06.04 Electronic Application for Medicare Savings Programs (MSP) from the Social Security Administration**

(Rev. 10/01/21)

For individuals who apply for the Low-Income Subsidy (LIS) with the Social Security Administration (SSA), the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires SSA to forward an electronic application to the state Medicaid agency to determine if the individual may be eligible for a Medicare Savings Program (MSP). Medicare Savings Programs are ABD/QMB, SLMB, and QI.

**101.07 Standard of Promptness**

(Eff. 01/01/14)

[CFR §435.912](http://www.ecfr.gov/cgi-bin/text-idx?SID=1b4fd0b5e9cdf2a1c8958e150774f5c3&node=42:4.0.1.1.6.10.73.13&rgn=div8)

Eligibility must be determined within the following timeframes.

**101.07.01 FI-Related Applications (MAGI Eligibility Groups)**

(Rev. 08/01/23)

Federal rules require that applications be approved or denied, and the applicant notified of the decision within 45 calendar days from the effective date of the application. The date the application is received is counted as the first day of the 45-day count. For more information see [MPPM 101.03.03](#MPPM_101_03_03).

* For all applications, if verification is needed from the applicant for information not reported on the application/addendum or for additional information regarding reported information, the eligibility specialist must follow the collateral call process defined in MPPM 101.07.04 before sending a [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, requesting the needed information. Allow at least fifteen (15) calendar days for the applicant to submit the information to allow the application to be processed within 45 calendar days. For example, if the DHHS Form 1233 is created on January 1, the due date will be January 16.
	+ If there is outstanding verification in the SOR and the SOR sends a request for information to the applicant, the system will generate the necessary timers and tasks. When Workload Pro serves the task into workflow, the eligibility specialist should respond and process the task. The eligibility specialist should not put the task into follow-up if the timer has expired.
	+ If generating a Manual Tracking Form and setting the follow-up date in OnBase, add an additional six (6) days to allow for mailing, scanning, and task creation in Workload Pro. This provides a total of 21 days from the date the DHHS Form 1233 is created and allow for the form to be mailed.

Example: For a manually generated DHHS Form 1233 created on January 1 and is due on January 16, set the follow-up date in OnBase as January 22.

* + When information is scanned into OnBase, a Workload Pro task will be generated for an eligibility specialist to evaluate.
		- If an applicant/beneficiary returns partial or incomplete information, refer to MPPM 101.07.05.
	+ If the task was generated due to other information being scanned into the OnBase, respond to the scanned information, and put the case back into follow-up for any remaining time.
	+ If an applicant/beneficiary returns partial or incomplete information before the follow-up date, process the returned information, and complete a collateral call to the applicant/beneficiary to identify the missing requested information and remind them the information needs to be returned by the original due date. Put the case back into follow-up.

Example: A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist will:

* + - Complete a collateral call to the applicant/beneficiary
		- List the missing information
		- Remind the applicant/beneficiary about the original due date
		- Update the Documentation Template;
		- Update any systems as appropriate; and
		- Put the case back into follow-up with the original January 22 follow-up date.
	+ If any applicant/beneficiary returns partial or incomplete information and the follow-up date has passed, deny based on failure to return requested information.
	+ A task is created in Workload Pro if the information is not returned by the follow-up date in OnBase. The Eligibility Specialist can process the task when it is claimed if the OnBase follow-up date was set properly.

**Note:**If the original follow-up date for a manually created tracking from does not include the additional six (6) days to allow for scanning and task creation in Workload Pro, put the case back into follow-up with the correct date if the date has not already passed.

**Date Examples**

|  |  |  |  |
| --- | --- | --- | --- |
| DHHS Form 1233Creation Date | Due Date | OnBaseFollow-upDate | Workload ProTask Date |
| January 1 | January 16 | January 22 | January 22 |
| February 15 | March 2 | March 8 | March 8 |
| March 26 | April 10 | April 16 | April 16 |

* The applicant has the primary responsibility for providing documentary evidence to support statements made on the application or to resolve any questionable information.
* The eligibility specialist will accept any reasonable documentary evidence provided by the applicant and will be primarily concerned with how adequately the verification proves the statements on the application or review form.
* If the applicant is unable to obtain information necessary to establish eligibility in a timely manner, the eligibility specialist must make a reasonable effort to assist the applicant.
* Refer to SC MPPM [101.07.03](#MPPM_101_07_03) for MEDS Extension of Promptness procedures.

**South Carolina specific standards** impose the following additional requirements:

* For all FI-related applications, **except Pregnant Women and Family Planning,** income must be verified before approval.
* If an application is denied solely for failure to provide information, and the applicant provides all needed verifications within 30 calendar days from the date on the denial notice, the date of the previous original application must be used to determine the effective date.
* If a case is closed solely for failure to return a Review and a completed review form is received within 90 calendar days from the date of the closure notice, the case should be treated as a review and continued eligibility for the beneficiary should be determined using the information provided and/or requesting additional information.
* If a case is closed solely for failure to return information and the applicant provides all needed verifications within 30 calendar days from the date on the denial notice, the date of the original application must be used to determine the effective date.

**Exception:** The Transitional Medicaid Quarterly Report cannot be treated as a “Review” if they are not returned by the 21st day of the month following the month in which the quarterly report was received. The beneficiary must re-apply for Medicaid.

* If a case is closed for failure to return and a review form is received more than 90 days after closure,
	+ If the review is signed, treat it as an application.
	+ If the review form is unsigned, treat it as an unsigned application (See MPPM 101.03.04C).
		- the review should be treated as an application once the individual has signed a [DHHS Form 3403](http://medsweb.scdhhs.gov/EligibilityForms/FM%203295.pdf), Your Rights and Responsibilities or the Review form.
		- Send the DHHS Form 3403 to the individual.
			* If the DHHS Form 3403 is returned within 15 days, use the date the review was received as the application date.
			* If the DHHS Form 3403 is returned after 15 days, use the date the form is received as the application date.
			* If the DHHS Form 3403 is not returned, no additional action is needed.
* Eligibility should be determined as if the verification was received with the first request. The case record should be documented with the date the information was received. If retroactive eligibility is requested, it should be based on the date of the previous application.
* An initial budget based on the applicant's self-reported income, pregnancy, citizenship, and family circumstances must be completed on the day an application is received to determine eligibility for Pregnant Women. If the eligibility specialist cannot process the application the date received, a decision must be made by the end of the next business day, and the reason the application could not be processed must be documented in the case record. It is important that the pregnant woman has coverage to access prenatal care as quickly as possible. Refer to MPPM 204.02 for specific instructions on processing OCWI (Pregnant Women) applications.

**101.07.02 SSI-Related Applications (Non-MAGI Eligibility Groups)**

(Rev. 08/01/23)

Federal rules require that applications be approved or denied, and the applicant notified within 45 calendar days from the date the application was filed. The date of application is counted as the first day of the 45-day count. The timeframe is 90 calendar days where disability must be determined before the eligibility determination can be completed.

* For all applications and addendums, if verification is needed from the applicant for information not reported on the application/addendum or for additional information regarding reported information, the eligibility specialist must follow the collateral call process defined in MPPM 101.07.04 before sending a [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, requesting the needed information. Allow at least fifteen (15) calendar days for the applicant to submit the information to allow the application to be processed within 45 calendar days. For example, if the DHHS Form 1233 is created on January 1, the due date will be January 16.
	+ If there is outstanding verification in the SOR and the SOR sends a request for information to the applicant, the system will generate the necessary timers and tasks. When Workload Pro serves the task into workflow, the eligibility specialist should respond and process the task. The eligibility specialist should not put the task into follow-up if the timer has expired.
	+ If generating a Manual Tracking Form and setting the follow-up date in OnBase, add an additional six (6) days to allow for mailing, scanning, and task creation in Workload Pro. This provides a total of 21 days from the date the DHHS Form 1233 is created and allow for the form to be mailed.

Example: For a manually generated DHHS Form 1233 created on January 1 and is due on January 16, set the follow-up date in OnBase as January 22.

* + When information is scanned into OnBase, a Workload Pro task will be generated for an eligibility specialist to evaluate.
		- If an applicant/beneficiary returns partial or incomplete information, refer to MPPM 101.07.05.
	+ If the task was generated due to other information being scanned into the OnBase, respond to the scanned information, and put the case back into follow-up for any remaining time.
	+ If an applicant/beneficiary returns partial or incomplete information before the follow-up date, process the returned information, and complete a collateral call to the applicant/beneficiary to identify the missing requested information and remind them the information needs to be returned by the original due date. Put the case back into follow-up.

Example: A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist will:

* + - Complete a collateral call to the applicant/beneficiary
		- List the missing information
		- Remind the applicant/beneficiary about the original due date
		- Update the Documentation Template;
		- Update any systems as appropriate; and
		- Put the case back into follow-up with the original January 22 follow-up date.
	+ If any applicant/beneficiary returns partial or incomplete information and the follow-up date has passed, deny based on failure to return requested information.
	+ A task is created in Workload Pro if the information is not returned by the follow-up date in OnBase. The eligibility specialist can process the task when it is claimed if the OnBase follow-up date was set properly.

**Note:** If the original follow-up date for a manually created tracking from does not include the additional six (6) days to allow for scanning and task creation in Workload Pro, put the case back into follow-up with the correct date if the date has not already passed.

**Date Examples**

|  |  |  |  |
| --- | --- | --- | --- |
| **DHHS Form 1233****Creation Date** | **Due Date** | **OnBase****Follow-up****Date** | **Workload Pro****Task Date** |
| January 1 | January 16 | January 22 | January 22 |
| February 15 | March 2 | March 8 | March 8 |
| March 26 | April 10 | April 16 | April 16 |

* For disability cases, the blindness/disability determination process outlined in SC MPPM 102.06.02A must be initiated within five (5) business days from the date of application.
* For SSI-related applications, income and resources must be verified using SSI verification standards.
* For persons residing in an institution or receiving home and community-based services, additional verifications must be obtained. For example, the Medicaid Eligibility Worker must verify:
1. that a sanctionable transfer did not occur,
2. the level of care determination, and
3. that all trusts were evaluated by the Eligibility, Enrollment and Member Services at the Department of Health and Human Services.
* If an application needs to be processed for both Non-MAGI and LTC services by an eligibility specialist, the LTC specialist must confirm that the information request was sent to the correct location (i.e., the information request was sent to the applicant at a facility and to the applicant’s authorized representative’s mailing address listed on the application or DHHS form 1282).
* If a separate determination was needed for both Non-MAGI and LTC and the application was found to be closed after 30 days and is unable to be re-opened, but both determinations were not completed, a new application case must be opened and pended with the original application date. (Refer to CGIS Manual 2.02 enter/Submit Application in Cúram)
* If an **application** is denied solely for failure to provide information, and the applicant provides all needed verifications within 30 calendar days from the date on the denial notice, the date of the original application must be used to determine the effective date.
* If a case is closed solely for failure to return a Review and a completed review form is received within 90 calendar days from the date of the closure notice, the case should be treated as a review and continued eligibility for the beneficiary should be determined using the information provided and/or requesting additional information.
* If a case is closed solely for failure to return information and the applicant provides all needed verifications within 30 calendar days from the date on the denial notice, the date of the original application must be used to determine the effective date.
* If a case is closed for failure to return and a review form is received more than 90 days after closure,
	+ If the review is signed, treat it as an application
	+ If the review form is unsigned, treat it as an unsigned application (See MPPM 101.03.04C).
		- the review should be treated as an application once the individual has signed a [DHHS Form 3403](http://medsweb.scdhhs.gov/EligibilityForms/FM%203295.pdf), Your Rights and Responsibilities or the Review form.
		- Send the DHHS Form 3403 to the individual.
			* If the DHHS Form 3403 is returned within 15 days, use the date the review was received as the application date.
			* If the DHHS Form 3403 is not returned, no additional action is needed.
* Eligibility should be determined as if the verification was received with the first request. The case record should be documented with the date the information was received. If retroactive eligibility is requested, it should be based on the date of the previous application.
* Refer to MPPM Chapter 304, Nursing Home - Waivered Services - General Hospital, for additional policy regarding persons residing in institutions or receiving home and community-based services.
	+ For individuals who have been determined to meet all eligibility requirements except the requirement to be institutionalized or receive home and community-based services for 30 consecutive days, the standard of promptness may be extended. On the 45th day following the application date, the Eligibility Worker should request an Extension of Promptness following MEDS procedures. (Refer to [MPPM 101.07.03](#MPPM_101_07_03)). The application should remain in pending status while the applicant is waiting to enter a facility or the waiver.
	+ When an applicant enters the nursing facility or waiver, the applicant/ authorized representative must be contacted to obtain the applicant’s current income or resources, and the case record must be updated with any information that has changed.

**101.07.03 Extension of Promptness**

(Rev. 12/01/22)

If an application has not been approved within the 45 or 90-calendar day standard of promptness and there is a valid reason, the corresponding Extension of Promptness code must be entered into MEDS/ Cúram. A code should only be entered into MEDS/ Cúram once the application is over the standard of promptness. The only exception is for an applicant who is awaiting the 30 consecutive day requirement for institutional care. The valid reason code may be entered into MEDS/Cúram once the applicant starts the 30-calendar day wait if approval would take place after the standard of promptness.

| **Procedure to Request an Extension of Promptness** |
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| **MEDS Procedures:*** Go to the Worker Alert Screen.
* Select alert number 572 for that budget group (BG).
* Press <PF12> to access the Extension of Promptness Screen.
* The Extension of Promptness Screen will display for the BG. The BG start date will display at the top of the screen. The period shown is the one for which you are requesting an extension.
* Select the appropriate reason for the extension.
	+ AD = Administrative or other delay that cannot be prevented (Note**:** To be used for situations such as awaiting clarification from State DHHS, the office is closed due to weather, MEDS was not available, or if an eligibility determination cannot be made on a non-citizen pregnant woman case within the 45 day standard of promptness).
	+ AR = Applicant requests delay until necessary information can be obtained
	+ CC = Awaiting proof of Citizenship information
	+ DD = Disability determination pending
	+ EF = Awaiting enrollment of the facility in the Medicaid program
	+ CI = Awaiting proof of Citizenship and Identity
	+ ID = Awaiting proof of Identity Information
	+ IT = Income Trust being established
	+ LC = CLTC level of care pending
	+ NB = Waiting placement on a Nursing Facility
	+ NT = Following up on verification requests
	+ RD = Reason to doubt allegations
	+ TD = Awaiting 30 consecutive days
	+ TP = Failure/delay in receiving third party source verification
* Type <MOD> in the Action field and press <Enter>.

The Eligibility Worker has the option of selecting the “Extension of Promptness” menu item from the Household Maintenance Menu. Eligibility Workers should use the budget group number to access the BG for which they are requesting the extension. On the screen, select the appropriate reason for the delay and type <MOD> in the Action field. |
| **Cúram Procedure** * Go to Application Case by clicking the Reference number found on the home dashboard under Pending Application cases
* From Application Case, click the Timers tab.
* Click the Action button on the far right of the banner.
* Select Extend. An Extend Timer pop up appears.
* Choose an Extension Reason from the dropdown.
* Click Save
* The Expiry Date will reflect the extension.

The appropriate procedure may be found at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/) or [Training Materials Portal-Non-MAGI](https://www1.scdhhs.gov/ees/TrainingPortal_NonMAGI/).Note: Extension of promptness can only be done at the application case level. It can’t be done once an application has been authorized in Cúram. |
| **Procedure to Open the Denied Budget Group** |
| **MEDS Procedure:** Eligibility workers should update RSN CD1 on ELD01 screen in MEDS with code 104 and the <MOD> to reopen the denied nursing home or the home and community based services budget group. MEDS screens ELD00 and ELD01 will have to be updated and <MOD>. Make Decision and Act on Decision to put the BG in Active status. |

101.07.04 Collateral Calls

(Rev. 04/01/23)

Prior to sending a DHHS Form 1233, Medicaid Eligibility Checklist, an Eligibility Specialist must attempt to call the applicant/beneficiary/AR to:

* obtain missing information,
* clarify what is still needed,
* attempt three-ways calls with 3rd parties, and
* answer questions.

Central eligibility is not required to complete a collateral call attempt pending and mailing out the DHHS Form 3400-A Addendum for MSP/QI electronic applications received from the Social Security Administration.

**If a checklist has been sent before and new information is needed, any calls made for the first checklist do not count towards the call attempts for the new request.**

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| Prior to attempting to call the Applicant/Beneficiary/AR, review System of Record and Documentation Template for documentation that may help with the determination as well as documentation of previous call attempts.* Determine whether the applicant/beneficiary has called the Member Services Contact Center (Conduent) and what resulted.
* Review the casefile to make sure required documentation has not already been received.
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| **Call Procedures** |
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| 1. Attempt to call the applicant/beneficiary/AR.

**Note:** If you do not reach the person on the initial call, follow current procedures, and leave a message that you will follow up with another call in 5 minutes. Do not put the case in "finish later" while waiting the 5 minutes. The initial and follow-up calls are part of the same attempt.1. Exhaust all options for obtaining needed information if you cannot reach the applicant. Attempt to call any legal representatives (such as a POA) or Authorized Representative(s) with proper documentation in the record. (Note: This is part of the same attempt, not a separate attempt.) If the applicant has multiple authorized representatives listed, call each one until you have spoken to someone or cannot reach anyone.
2. If the applicant/beneficiary and any legal representatives or Authorized Representatives cannot be reached, **send the checklist(s) at this time**.
3. Document each attempted call in the SOR and in the General Comments section on the Documentation Template. Record all calls on the same day as part of one entry.
* Attempted to call applicant/beneficiary/AR. Provide details of the person(s) called, why, and result. The attempt may include phone calls to several individuals if the applicant/beneficiary has more than one Authorized Representative. Document each contact as appropriate.
	+ If the call is successful and needed information could not be obtained during the collateral call, then:
	+ Send DHHS Form 1233 checklist to the applicant, beneficiary, and each of the authorized representatives.
	+ Send case to follow up in OnBase for a total of 21 days (15 days + 6 days to allow for scanning).
	+ If the call is NOT successful, then
	+ Leave a voice message according to current process.
	+ Send DHHS Form 1233 checklist to the applicant, beneficiary, and each of the authorized representatives.
	+ Send case to follow up in OnBase for a total of 21 days (15 days + 6 days to allow for scanning).
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**101.07.05 Partial Information**

(Eff. 08/01/23)

* If an applicant/beneficiary returns partial or incomplete information before the follow-up date, process the returned information, and complete a collateral call to the applicant/beneficiary to identify the missing requested information and remind them the information needs to be returned by the original due date. Put the case back into follow-up.
* If any applicant/beneficiary returns partial or incomplete information and the follow-up date has passed, deny based on failure to return requested information.

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| Diagram  Description automatically generated |

**Example 1**

A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist gets the task on January 12 and:

* Completes a collateral call to the applicant
* Lists the missing information
* Reminds the applicant/beneficiary about the original due date
* Updates the Documentation Template
* Updates any systems as appropriate; and
* Puts the case back into follow-up with the original January 22 follow-up date.

**Example 2**

A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist gets the task on January 12 and:

* Attempts a collateral call to the applicant but is unsuccessful
* Updates the Documentation Template
* Updates any systems as appropriate; and
* Puts the case back into follow-up with the original January 22 follow-up date.

**Example 3**

A DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist gets the task on January 25 and:

* Checks OnBase to make sure the information is not in the record
* Updates the Documentation Template; and

Denies the application for Failure to Return Information.

**101.08 Disposition of Applications/Active Cases**

(Rev. 02/10/21)

As part of the initial and continuing eligibility process, the information provided by the applicant/beneficiary and/or obtained from other sources must be verified, documented in the case record, and evaluated in accordance with the program requirements. Components of this process are explained below.

An application or review must be evaluated based on the date order received. Treat the form with the later date as a reported change. The applicant or beneficiary must be contacted to clarify any conflicting information which results in a change in benefit level.

The Documentation Template in OnBase must be completed for all case decisions in MEDS or Cúram with the exception of cases that are processed straight through without worker intervention. The template should be started by the eligibility worker who first begins processing an application or review and updated by each subsequent eligibility worker throughout the process until a decision is completed.

**101.08.01 Verification**

(Rev. 10/01/13)

[CFR §435.945](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.76.25&rgn=div8) - [CFR §435.956](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.76.30&rgn=div8)

Verification is the substantiation, confirmation, authentication, or validation of an assertion, a claim, or previously submitted information. Refer to SC MPPM Chapter 102 and program specific instructions for verification procedures.

* The applicant/beneficiary has the primary responsibility for providing documentary evidence to support statements made on the application or, if necessary, to resolve any questionable information.
* The Eligibility Worker will accept any reasonable documentary evidence provided by the applicant/beneficiary and will be primarily concerned with how adequately the verification proves the statements on the application or review form.
* Documentary evidence provided by the applicant/beneficiary must never be discarded, destroyed, ignored, or altered by the Eligibility Worker.
* If the applicant/beneficiary is unable (physically, emotionally, mentally, or due to circumstances beyond his control) to obtain information necessary to establish eligibility in a timely manner, the Eligibility Worker must offer assistance.
* When the applicant/beneficiary claims no income or resources, the Eligibility Worker must fully document the facts provided to substantiate these claims in the MEDS/Cúram notes screen.

**Collateral Contacts**

If it is necessary to request information from banks, insurance companies, or other sources that do not disclose information without authorization, such authorization must be obtained in writing from the applicant/beneficiary using [SC DHHS Form 943](http://medsweb.scdhhs.gov/EligibilityForms/FM%20943.pdf), Information Release Form.

* However, permission from the applicant/beneficiary for needed verifications other than those specified above is not necessary if the applicant/beneficiary (or a responsible person acting on his behalf if he/she is incapacitated or incompetent) signs a dated application form.
* Public records or records available from other agencies may be consulted without the consent of the applicant/beneficiary.
* When information is sought from a collateral source, the applicant/beneficiary must be given a clear explanation of the information needed, what the information is needed for, and how it will be used.
* When the applicant/beneficiary has a valid objection to the use of a particular source, his reasons for objecting should be considered and another source selected, if reasonable.
* However, certain sources, such as the employer of the applicant/beneficiary, can be contacted over his objection.
* If someone has definite facts relating to certain eligibility criteria, he/she may be used as a collateral source of information. He must be advised of the necessity to reveal his identity to the applicant upon request, if the information provided results in an adverse action.
* If the collateral source does not agree to have his identity revealed, the information obtained from him/her may not be used to take action. This information may only be used as a lead toward securing other evidence.
* Documentary evidence provided by a collateral source must never be discarded, destroyed, ignored, or altered by the Eligibility Worker.

**101.08.02 Documentation**

(Rev.07/01/15)

[CFR §435.945](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.76.25&rgn=div8) - [CFR §435.956](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.76.30&rgn=div8)

Documentation is the written record of verified information methods used. All information pertaining to the eligibility of the applicant/beneficiary must be recorded in the case record. Documentation provided by an applicant/beneficiary must never be discarded, destroyed, ignored, or altered by the Eligibility Worker.

* The information is evaluated, taking into consideration legal requirements and program limitations, to determine if all eligibility criteria are met.
* If several source’s give conflicting information, the reliability of each source must be evaluated, and the case record should specify which source was accepted and why. The final determination of eligibility is made based on the most reliable source available.
* The applicant must be informed of his responsibility to cooperate in supplying the information and documentation necessary to complete the eligibility process.
* The Eligibility Worker will provide to the applicant, in writing, an outline of the information that the applicant is responsible for obtaining. [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, may be used for this purpose. A copy of the request for information should be placed in the case file.
* If an applicant does not provide the information necessary to determine eligibility or continued eligibility within the specified timeframe, the Eligibility Worker should take action to deny/close. MEDS/Cúram will then send an appropriate notice to the applicant/beneficiary.
* The notice will inform the applicant/beneficiary that assistance is being denied or discontinued because of failure to provide information necessary to determine or re-determine eligibility.
* Current documentation is required to make an eligibility determination. Unless otherwise specified, documentation is considered current if it is dated within 35 calendar days prior to and including the:
	+ Application signature date;
	+ Date the application/review is received/stamped in a SC DHHS office; or
	+ Date an eligibility decision is completed in MEDS/Cúram on a review.

**101.08.03 Application Actions**

(Rev. 12/01/21)

All applications will be subject to one of the following actions:

* **Approval** – When all of the eligibility criteria are met, the application is approved.
* **Denial** – When one or more eligibility criteria are NOT met, the application is denied. Death is not an appropriate reason to deny an application. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion. An application for TEFRA, Nursing Home, or HCBS that requires both a level of care and disability determination cannot be denied by the Eligibility Worker until both decisions have been received.
* **Withdrawal** – An application is considered withdrawn when the applicant indicates in writing his intent not to continue with the eligibility process.

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| **Case Review Prior to Making a Determination**Prior to making an eligibility determination, the worker must ensure the case file is complete for all eligibility criteria based on policy. This includes reviewing the case file for the following:* Required documents are in the case file (e.g. signed application, review form, Adoption decrees)
* Information from the application and other documents is correctly entered into the System of Record
* Required verification documents for financial, non-financial and categorical eligibility criteria are in OnBase and recorded on the Documentation Template and/or System of Record where appropriate (such as SSN if not system verified, MAO99, Level of Care)
* Documentation Template has been completed, including details of verified information such as for income or resources
* The determination reflects reported changes found on application, review forms or other reported changes received in person, by mail, fax or phone
* Information requested via DHHS Form 1233: Was requested information needed to make a determination? The worker should not deny/close a case for failure to return information if the requested information is not needed. (For instance, information is already in the case file)
* Completed budget workbook where appropriate
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| **Cúram Certification Periods for Non-MAGI**A PDC (Product Delivery Case) is created by Cúram when an Income Support Case is assessed (or reassessed) and at least one case member qualifies for at least one month of coverage.* The Certification Period is generated along with the PDC.
* It represents a date range in Cúram within which eligibility determinations are made. Cúram makes determinations for each case member within the appropriate timeframe. This includes retroactive coverage and ongoing coverage. The combined Coverage Periods usually equal the total length of the Certification Period.
* Cúram then determines eligibility for each case member for each month within the Certification Period.
* The end date of the Certification Period is 12 months from the decision date.

**Editing the Certification Period**Sometimes a Certification Period in Cúram needs to be extended. The Certification Period should be one year from the last day of the month prior to the month the case is authorized. This Policy applies to both applications, reviews, and some changes. **EXAMPLE**Application received 1.10.2021 and processed on 3.10.2021. The Certification Period should be extended to 2.28.2022.When editing the Certification Period in Cúram, the **From Date** and **Date Received** fields must **not** be modified. The eligibility specialist must edit the **To Date** field only.  |

**101.08.04 Effective Date of Eligibility/Accrual Rights**

(Eff. 01/01/14)

In most cases, eligibility begins with the month of application. (Refer to individual program chapters for rules applicable to specific categories.)

**101.08.05 Case Actions**

(Rev. 03/01/20)

All active cases will be subject to one of the following actions:

* **Review** – (Refer to SC MPPM [101.10](#MPPM_101_10).)
* **Closure/Termination** - When the beneficiary no longer meets the eligibility criteria, the beneficiary’s eligibility is terminated and/or the case is closed, if appropriate. This action may also be taken if the beneficiary requests to have the case closed.

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| **Case Review Prior to Making a Determination**Prior to making an eligibility determination, the worker must ensure the case file is complete for all eligibility criteria based on policy. This includes reviewing the case file for the following:* Required documents are in the case file (e.g. signed application, review form, Adoption decrees)
* Information from the application and other documents is correctly entered into the System of Record
* Required verification documents for financial, non-financial and categorical eligibility criteria are in OnBase and recorded on the Documentation Template and/or System of Record where appropriate (such as SSN if not system verified, MAO99, Level of Care)
* Documentation Template has been completed, including details of verified information such as for income or resources
* The determination reflects reported changes found on application, review forms or other reported changes received in person, by mail, fax or phone
* Information requested via DHHS Form 1233: Was requested information needed to make a determination? The worker should not deny/close a case for failure to return information if the requested information is not needed. (for instance, information is already in the case file)
* Completed budget workbook where appropriate
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**101.08.06 Ex parte Determinations**

(Eff. 04/22/22)

When Medicaid eligibility for an applicant/beneficiary is denied or terminated under one coverage group, the Eligibility Worker must determine whether each applicant/ beneficiary applying for or receiving coverage is eligible under any other coverage group. This determination is called an ex parte determination. An ex parte determination is a Medicaid eligibility decision using information that is readily available to the Eligibility Worker with minimal contact with the applicant/beneficiary. If during the process it is determined a beneficiary may be eligible for Medicaid, but additional information is required to make a final determination, the beneficiary will remain eligible in the original category while the Eligibility Worker secures the documentation needed to make the determination for the new category. If it is decided that the beneficiary is not eligible for the new category, the beneficiary does not have to repay benefits received during this period.

For an ex parte determination to be made, the Eligibility Worker must be in the process of making a decision on a current application, review, or reported change. If the Eligibility Worker is denying or closing the applicant/beneficiary for failure to return information or a review (an administrative denial or termination), the Eligibility Worker is not required to complete an ex parte determination.

All applicants/beneficiaries who are no longer eligible for Medicaid will be assessed for eligibility of other affordable insurance programs. If the individual is assessed as potentially eligible their application data will be sent to the Federal Marketplace (FFM) for determination of eligibility for these programs. Do not refer administrative denials and terminations to the FFM.

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| **Example 1**Jack Spratt, who is receiving PCR, reports a change in income. The amount he now receives is over the income limit. The eligibility worker must review the record and complete an ex parte determination.**Example 2**Rip Van Winkle failed to return his annual review. The eligibility worker does not complete an ex parte determination. |

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| **Procedure**Applications processed in MEDS for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the FFM. An email must be sent to SP\_FFMTransfer@scdhhs.gov. 1. Subject Line of the email: Household Number
2. Body of the email: First and Last Name

Note: Applications processed in Cúram (HCR) will be referred automatically to the FFM.Applications processed in Cúram (CGIS) for individuals who do not have Medicare and who are either denied for full benefits or approved for Family Planning (PCAT 55) must be referred to the Federally Facilitated Marketplace (FFM). An email must be sent to SP\_FFMTransfer@scdhhs.gov.1. Subject Line of the email: Household Number/Income Support Case Number
2. Body of the email: First and Last Name of the applicant

**Note:** Medicare recipients must not be referred to the FFM because they already have health insurance coverage.**Do not** refer administrative denials (i.e., failure to return information) to the FFM. |

Examples of readily available information used to complete an ex parte determination include case record documentation and system interface information. Information in an ACTIVE case is considered accurate if the worker has no reason to believe otherwise. Information in an INACTIVE case can be relied upon if the information was obtained within one year and the worker has no reason to doubt its accuracy.

**Ex parte Guidelines**

1. Readily available information must be reviewed to find out if each beneficiary receiving or applying for Medicaid is potentially eligible under any other program. The last application must be reviewed to see if the applicant/beneficiary may be eligible in another category. Check SDX, BENDEX, and the latest application or review to find out if any beneficiary is receiving or has received disability or claims to be disabled. For specific procedures for Deemed Babies, refer to SC MPPM 204.02.02A.

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| **Example 3**A mother and child are receiving PCR. Later, when the child turns age 19, the case is to be closed. On the last review, the mother indicated she was disabled. She must be given the opportunity to be evaluated for ABD before terminating her PCR coverage. |

1. After reviewing the available information:

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| **Procedure for an Ex Parte Determination** |
| **MEDS Procedure*** If the applicant/beneficiary is eligible in a different payment category, approve the case in the new category.
* If the applicant/beneficiary is not eligible in any other payment category, deny/ terminate the original payment category using the original denial/termination reason.
* If the applicant/beneficiary appears potentially eligible based on the case record, but all information is not available to make the decision, contact the applicant/ beneficiary for the required information. The [SC DHHS Form 1233-E](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233-E.pdf), Medicaid Eligibility Ex Parte Checklist, must be sent to the beneficiary requesting the information necessary to make a final determination on the case. The beneficiary will be given 10 calendar days to provide this information. The 10 days begin on the date the SC DHHS Form 1233-E is sent.
	+ When setting the follow-up date in OnBase, add an additional six (6) days to allow for scanning and task creation in Workload Pro (WLP). For example, if a DHHS Form 1233-E is due on January 16, set the follow-up date in OnBase as January 22.
	+ A task will be created in WLP either when information is returned by the individual or when the follow-up date is reached. Once a task is claimed, a worker can take the appropriate action.
	+ For current beneficiaries, continue the eligibility in the existing category. If the case is currently due for review, the Eligibility Worker must enter the Form Received Date in MEDS on the WKR008 (Regular Review) screen to avoid a system closure. Make Decision can be made at this time, but the Eligibility Worker must not call Act on Decision. The Anticipated Closure Date (ACD) must be set to 90 calendar days in the future and the Next Review Date (NRD) must be set for 12 months. Do not create a new budget group for the alleged payment category. If the beneficiary returns all required information within 10 calendar days, the Eligibility Worker will proceed with making the eligibility determination. If the beneficiary is eligible under the alleged payment category, ex parte to the new payment category and set NRD to one year. If the beneficiary is determined ineligible for the alleged payment category, the worker must close out the existing budget group using the original denial/termination reason code. The ACD must be removed and the system may prompt you to Make Decision (to update the eligibility end date) before continuing with Act on Decision.
	+ If the requested information is not returned within 10 calendar days, the Eligibility Worker must proceed with closing the case. If at any point ineligibility is determined, coverage can be denied or terminated. It is not necessary that all eligibility criteria be verified before denial or closure can take place. **Exception:** If the potential category is TEFRA, Nursing Home, or HCBS, both a level of care and disability determination decision must be made before the application is denied.
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1. If a disability decision is required in the potential category, refer to SC MPPM 102.06.02A for the blindness/disability determination process.
* If an applicant/beneficiary indicates disability but describes a condition that would realistically not be considered disabling, such as admitting to having high blood pressure that is under control with medication but no other problems, then this individual would not be considered disabled. Also, if there is a recent Social Security denial for disability and there is no allegation of a change in condition, an independent determination is not necessary. If there is any reasonable doubt, the Eligibility Worker should complete a disability determination. Regardless of the applicant/beneficiary’s medical condition, if he insists on a disability determination, one must be completed.
1. If a beneficiary receives a closure notice (that is, was Medicaid eligible and the case is going to close or has been closed) and requests a continuation of coverage within 30 calendar days from the date on the closure notice and appears potentially eligible based on the alleged categorical requirements, coverage must be re-instated in the original category. The DHHS Form 1233-E must be sent to the beneficiary requesting the information necessary to make a final determination on the case. The beneficiary will be given 10 calendar days to provide this information. The 10 days begin on the date the DHHS Form 1233-E is sent.

**Reminder:** Add six (6) additional days when setting the follow-up date in OnBase.

* If a disability decision is required in the potential category, refer to MPPM 102.06.02A for the disability/blindness process. When the information is received, the Eligibility Worker will proceed with making a final determination on the case.
* If the beneficiary requests coverage to continue but does not indicate any reason that falls under a potential category, this must be documented in the record, and the process for termination continues.
1. If an applicant receives a denial notice (that is, has not been approved for Medicaid and the application has been denied in MEDS) and requests reconsideration for another category within 30 calendar days from the date on the notice and appears potentially eligible based on the alleged categorical requirements, the original application date can be used. Pend the application in MEDS using the potential category. The DHHS Form 1233-E must be sent to the applicant requesting the information necessary to make a final determination on the case. The applicant will be given 10 calendar days to provide this information. The 10 days begin on the date the DHHS Form 1233-E is sent.

**Reminder:** Add six (6) additional days when setting the follow-up date in OnBase.

* If a disability decision is required in the potential category, refer to MPPM 102.06.02A for the disability/blindness process. When the information is received, the Eligibility Worker will proceed with making a final determination on the case.
* After making the final determination for the potential category, approve or deny the application in MEDS using the appropriate reason.
* The case cannot be ex parted if the request is received after 30 calendar days. If the request is made after 30 calendar days, a new application is required.
1. For Pregnant Women cases, once the 12-month post-partum period ends, the Eligibility Worker must determine if the beneficiary is eligible for Medicaid under any other coverage group with full benefits (ex. PCR, PHC). If the beneficiary is not eligible for a full benefit category, then the Eligibility Worker must consider eligibility for Family Planning. If the applicant/beneficiary is not eligible under any other coverage group, she will be assessed for eligibility of other affordable insurance programs. If she is assessed as potentially eligible, her application data will be sent to the Federal Marketplace (FFM) for determination of eligibility for these programs.
2. Minor applicants/beneficiaries cannot be ex parted from any Medicaid category to Family Planning unless requested by a parent or legal guardian or by the minor. An adult of childbearing age who applies for or receives Medicaid benefits can be considered for all Medicaid categories for which eligibility can be established, including Family Planning and for eligibility for other affordability insurance programs through the Federally Facilitated Marketplace.

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**101.08.07 Continuous Eligibility for Children Under Age 19**

(Rev. 04/22/14)

If a child under age 19 is approved for full range of Medicaid benefits, eligibility continues for 12 months regardless of changes in family income or other circumstances. This policy should be applied when determining or re-determining eligibility for a child under age 19, regardless of the category. This continuous coverage may also be referred to as a protected period. When approving a Budget Group (BG) with a child under 19, enter the Next Review Date (NRD) on ELD01 as one year from the current date. The Protected Period End Date (PPED) will be set to one year from the decision date.

The following exceptions apply:

* If a child dies, his eligibility should be terminated.
* If a child moves out of state, his eligibility should be terminated.
* If a child attains the maximum age for the category, an ex parte determination must be completed.
* If a child becomes an inmate of a public institution, the Eligibility Worker must indicate an “I” on the ELD02 screen in MEDS. (Refer to SC MPPM 102.09.01)
* If a child under age 19 is eligible for Pregnant Woman at the end of her postpartum period, determine if she is eligible for PHC for the remainder of her protected period.
	+ If eligible for PHC, move her to the new category. Do not change PPED.
	+ If she is not eligible for PHC, leave her in PW until her protected period ends.
* If the beneficiary is approved for retroactive coverage but not approved for the application month.
* If a child is approved for coverage and has been given up to 90 calendar days as a reasonable opportunity to supply verification of Citizenship and/or Identity and verification is not returned, his eligibility can be terminated.

**101.08.08 SSI Recipients in E01 Payment Status**

(Eff. 01/01/14)

Some SSI recipients are eligible for SSI, but do not receive a payment. These recipients are identified on SDX with payment status code E01: Eligible for Federal and/or State benefits based on eligibility computation, but no payment is due based on the payment computation. The SDX subsystem establishes Medicaid as payment category 32 (ABD) with a review date six months from the date the payment status code was received and processed. The case is automatically assigned to the default Eligibility Worker for the county. The Eligibility Worker receives alert 350: BUDGET GROUP HAS BEEN ASSIGNED TO YOU. These cases must not be transferred to the Division of Central Eligibility Processing.

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| **Procedure for Processing E01 Payment Status Review:** |
| **MEDS Procedure:*** Sixty days before the date the review is due, a review form is automatically sent to the beneficiary.
* When the review form is received in the county:
	+ Check MEDS screens ELD00, ELD01, or ELD02 using the assigned BG number on the review. The system ID on the screen will show SDX1000.
	+ SDX information screen may also be checked. SDX01 or SDX03 will show an E01 payment status code.
* Establish a case record using the review form as the application and complete the review obtaining appropriate verification.
* Enter any missing information needed to complete the review into MEDS.
* If a review form is not returned, the case will close automatically.
 |

**101.08.09 Case Record Retention Schedule**

(Eff. 01/01/14)

Case Records are to be retained in the active file until denial of the request for, or termination of participation in the Medicaid Program. Once assistance is denied or terminated, transfer the case record to the inactive file. The record is retained in the inactive file within the agency for a minimum of four years. After this period, the case record can be destroyed.

If an audit by or on behalf of the state or federal government has begun but is not completed at the end of the retention period, the records will be retained until the resolution of the audit findings, then destroyed.

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**101.09 Written Notification**

(Eff. 09/01/17)

An applicant/beneficiary must be given written notification of any positive or negative action taken on his case. This requirement applies to applications and active cases. If a notice is not automatically sent by MEDS or Cúram, the Eligibility Worker must send a manually generated notice. To send a notice manually, navigate to the [Medicaid Eligibility Forms](http://medsweb.scdhhs.gov/noticelisting.htm) library of manual notices, choose the appropriate notice and fill out the relevant information in the fields provided. Scan the completed notice into OnBase and mail a paper copy to the primary address listed on the case.

**101.09.01 Applications**

(Eff. 01/01/14)

The agency must send each applicant a written notice of the decision on his application. If eligibility is denied, the notice must include the reason for the action, the specific regulation supporting the action, and an explanation of the right to request a hearing. Applicants requesting retroactive coverage must receive a written notice of eligibility in the retroactive period. The [SC DHHS Form 3229-A](http://medsweb.scdhhs.gov/EligibilityForms/FM%203229-A.pdf), Notice of Approval\Denial for Medical Assistance/Optional Supplementation, is used to notify applicants when retroactive coverage is added to MEDS or Cúram. The appropriate procedure for adding retroactive eligibility in Cúram may be found in the [Processing Retroactive Medicaid](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Processing%20Retroactive%20Medicaid.pdf?csf=1&web=1&e=1crXe8) job aid at the [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/).

**101.09.02 Active Cases**

(Rev. 01/01/14)

When an action is taken on an active case due to a change in circumstances, the beneficiary must be notified in writing. The agency will send an appropriate notice to the beneficiary. A beneficiary must be given advance notice about any adverse action, for example termination or reduction of benefits. The notice must include the reason for the action, the specific regulation supporting the action, and an explanation of the right to request a hearing.

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| **Procedure for Re-Opening a Budget Group** |
| **MEDS Procedure**A MEDS notice is generated anytime an individual in a budget group closes. Should the individual need to be re-opened, the eligibility worker can enter Reason Code 110 on ELD02 in MEDS to re-open the closed budget group member. The Budget Group Status (active, closed or pending) and Action Type (review or maintenance), will remain the same as before the re-open.**Cúram Procedure:**The appropriate procedure may be found in one of the following job aids at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/). * [Resume Benefits Closed Less Than 30 Days](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Resuming%20Benefits%20Closed%20Less%20Than%2030%20Days.pdf?csf=1&web=1&e=vScfuf) or
* [Resume Benefits Closed Over 30 Days](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Resuming%20Benefits%20Closed%20Over%2030%20Days.pdf?csf=1&web=1&e=7wDlVb)
 |

**101.09.03 Advance Notice**

(Rev. 09/01/17)

To meet the advance notice requirement, the agency must generate the Notice of Adverse Action to be mailed at least fifteen (15) calendar days before the date of action. The advance notice period may be shortened to five (5) calendar days before the date of action if the agency has facts that indicate probable fraud, and the facts have been verified by secondary sources.

A Notice of Adverse Action may be mailed on the date of the action, if:

* The beneficiary died.
* The beneficiary provides a signed statement that he/she no longer wishes services or that he/she waives his right to a fifteen (15) calendar day notice.
* The beneficiary has been admitted to an institution where he/she is ineligible for further services (such as an inmate of a public institution).
* The beneficiary's whereabouts are unknown and mail addressed to him/her is returned indicating no forwarding address.
* The agency verifies that the beneficiary has been approved for Medicaid services in another State.
* The beneficiary no longer meets level of care.

Notices meeting these timeframes are considered adequate. In some instances, applicants/beneficiaries are notified of case actions by automated letter that meet the timeframes discussed above.

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| **Procedure for Sending a Manual Notice** |
| **Procedure**:In some scenarios, MEDS and Cúram are not triggered to send an auto-generated notice. In those cases, the Eligibility Worker must send a manually generated notice. To send a notice manually, navigate to the [Medicaid Eligibility Forms](http://medsweb.scdhhs.gov/noticelisting.htm) library of manual notices, choose the appropriate notice and fill out the relevant information in the fields provided. Scan the completed notice into OnBase and mail a paper copy to the primary address listed on the case.If eligibility was terminated and MEDS or Cúram did not automatically create and send a closure notice, the eligibility worker must:* Re-establish eligibility for the impacted members,
* Create a manual closure notice with the appropriate closure reason and manual citation,
* Scan the completed notice into OnBase,
* Add a case note in MEDS or Cúram AND on the Documentation Template
* Mail a paper copy to the primary address listed on the case, and
* Close the case allowing for the correct 15-day advance notice.
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**101.10 Review**

(Rev. 02/01/23)

A redetermination of eligibility must be completed when a change in circumstances is reported or identified. The redetermination must be completed within 10 calendar days from the date that notification of the change is received in the eligibility office. It must be documented in OnBase and on the appropriate notes screen in MEDS/Cúram how the change was evaluated by the Eligibility Worker and what impact the change may have had on eligibility. If required, the Eligibility Worker must take all actions in MEDS/Cúram and send the appropriate notices to the beneficiary. If a beneficiary with active Medicaid benefits submits an application, treat the application as a change of circumstances.

Eligibility must be reviewed annually or according to the Medicaid Review Schedule that follows. A review is considered timely if it is received prior to the Next Review Date (NRD) in MEDS **AND** the review is completed by the NRD or within ten (10) calendar days of receipt, whichever is later.

If an applicant or beneficiary with active Medicaid benefits submits an application or review form and answers the question: “Do you want health coverage?”, with ***No***, attempt a collateral call to address the discrepancy. If a collateral call is unsuccessful, process the application or review as if the person answered ***Yes***.

If an applicant or beneficiary with active Family Planning coverage submits an application or review form and answers the question: Do you want to apply for Family Planning benefits?, with ***No***, attempt a collateral call to address the discrepancy. If a collateral call is unsuccessful, process the application or review as if the person answered Yes.

The details of the collateral call must be documented on the Documentation Template. This includes the date and time of the call, if the Eligibility Specialist spoke to the beneficiary, the beneficiary’s answer, and the case action taken by the Eligibility Specialist.

Listed below are examples of when conflicting information needs to be clarified with the beneficiary.

|  |
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| **Example 1**Jack Terrier, who is receiving Family Planning, submits an application and indicates he is applying for coverage. Jack answered ***No*** to the Family Planning question on the application. A collateral call is made but was not successful. Family Planning coverage will continue unless the person becomes eligible for a full coverage category.**Example 2**Jack Terrier, who is receiving Family Planning, submits a MAGI annual review form and indicates he is applying for coverage. Jack answered ***No*** to the Family Planning question on the review form. A collateral call is made, and Jack indicates he wants to continue current coverage if not eligible for full coverage. Family Planning coverage will remain active.**Example 3**Jack Terrier submits an application applying for coverage for himself. He indicates he is not applying for coverage for his children, but they are already covered by Children’s (PHC/CHIP) Medicaid. A collateral call is made but was not successful. Children’s (PHC/CHIP) Medicaid will remain in effect.**Example 4**Jack Terrier submits a MAGI annual review form and indicates no one in the household is applying for coverage, but everyone in the household has active Medicaid coverage. A collateral call is made, and the beneficiary states the household no longer wants coverage. Coverage can be closed for all members. |

**Note**

When completing reviews in MEDS, all screens must be updated, beginning with Create Household (HMS03.) If there are children under age 19, enter the NRD on ELD01 as one year from the current date. The Protected Period End Date (PPED) will be set to one year from the decision date.

| **Medicaid Review Schedule** |
| --- |
| **Eligibility Category** | **Frequency** | **Review Requirement** |
| 10 MAO – Nursing Home | Annually |  |
| 11 Transitional Medicaid (TM) | Once | If requirements for Transitional Medicaid were met, action required in 18th month. A computer-generated notice (WKR004) will be sent to the beneficiary. If requirements for Transitional Medicaid were not met, action required in 6th month of Transitional Medicaid. In either situation, ex parte determination required in last month. |
| 12 PW – Deemed Infants (reason code “CB” or “DB”)  PW – Infants up to age 1 (reason code “PB”) | At Age OneOne Year |  |
| 1. Special Needs/Subsidized Adoption
 | No Review |  |
| 14 MAO - General Hospital | Annually | An alert will be generated quarterly to verify continued hospitalization. |
| 15 MAO - Other (definition dependent upon reason code) | Annually |  |
| 16 1977 Pass-Along (Pickle) | Annually |  |
| 17 Early Widows/Widowers | Annually |  |
| 18 Disabled Widows/Widowers | Annually |  |
| 19 Disabled Adult Children | Annually |  |
| 20 Pass-Along Children | Once | When child reaches age 18, complete ex parte determination. |
| 31 Title IV-E Foster Care | No Review | Eligibility maintained as long as Title IV-E eligible. |
| 32 Aged, Blind and Disabled (ABD) |  Annually  |  |
| 33 ABD – Nursing Home | Annually |  |
| 40 Working Disabled (WD) | Annually |  |
| 48 Qualifying Individuals (QI) | Annually |  |
| 50 Qualified Disabled and Working Individuals (QDWI) | Annually |  |
| 51 Title IV-E Adoption Assistance | No Review |  |
| 52 SLMB1 | Annually |  |
| 54 SSI Nursing Home Beneficiary | No Review |  |
| 55 Family Planning (FAMILY PLANNING) | Annually |  |
| 56 Proviso Children (not Medicaid) | No Review | (Left for historical purposes) |
| 57 Katie Beckett (TEFRA) Children | Annually |  |
| 59 Low Income Families (LIF)/ Parent Caretaker Relative (PCR) | Annually |  |
| 60 Regular Foster Care (RFC) | Annually - for children under age 18. No review for children ages 18 through 20. Ex parte determination required at age 21. |  |
| 61 Former Foster Care (FFC) | No Review | Eligibility maintained until age 26 |
| 70 Refugee Assistance Program (RAP) | No Review -Entitled to 12 months of Refugee Assistance benefits. |  |
| 71 Breast and Cervical Cancer Program (BCCP) | Annually or Semi-Annually | Every six months for pre-cancerous lesion cases (CIN 2/3 or atypical hyperplasia |
| 80 Supplemental Security Income (SSI) | No Review |  |
| 81 SSI with an Essential Spouse | No Review |  |
| 85 Optional State Supplemental (OSS) Only | Annually |  |
| 86 OSS with SSI | No Review |  |
| 87 Optional Coverage for Women and Infants (OCWI) - Pregnant Women | No Review |  |
| 88 Optional Coverage for Women and Infants (OCWI) - Infants Partners for Healthy Children (PHC) - up to age 19 | Annually |  |
| 90 Qualified Medicare Beneficiaries (QMB) | Annually |  |
| 91 Ribicoff Children | Annually | (Left for historical purposes) |

**101.10.01 MAGI Renewals**

(Rev. 04/01/22)

The eligibility of Medicaid beneficiaries enrolled in a MAGI eligibility group must be renewed once, and only once, every 12 months. The agency must make the redetermination without requiring additional information from the individual if able to do so based on the individual’s case or current information available. If the agency is able to make the redetermination without requiring additional information from the individual, the agency must notify the individual of the eligibility determination, the basis for the determination, and have the individual indicate if any information in the case is inaccurate.

If the agency is unable to make the redetermination without requiring additional information from the individual, the agency must provide the individual with the following:

* A pre-populated renewal form,
* A response time of thirty (30) days from the date of the renewal form to answer and provide necessary information; and
* Notice of the agency’s eligibility decision once the review is complete.

The agency must also:

* Verify any information provided by the beneficiary;
* Reconsider the eligibility of an individual who was terminated for failure to submit a renewal form or necessary information. If an individual submits a renewal form or necessary information within ninety (90) days following the termination date, his eligibility should be considered without requiring a new application; and
* Not require an individual to complete an in-person interview as part of the renewal process.

**Extending the Certification Period when there is a Change of Circumstance**

Medicaid beneficiaries are required to report changes in their circumstances to SCDHHS within ten (10) days. Eligibility specialists must act on those changes as they are reported. Some changes may require a case review, and some changes may not. When completing a case review, extend the Certification Period to one year from the last day of the month before the month the case is authorized.

**When to extend the Certification Period**

If a change of circumstance is reported within 90 days of the Certification Period end date:

* A full case review must be completed
* The Certification Period must be extended

If a change of circumstance is reported within 90 days of the last case review or case approval:

* Update the evidence only on the Evidence Dashboard
	+ Add required verifications
	+ Apply Changes
	+ Check Eligibility
* Do not complete a full case review
* Do not extend the Certification Period

If a change of circumstance is reported that does not impact eligibility:

* Update the evidence only on the Evidence Dashboard
	+ Add required verifications
	+ Apply Changes
	+ Check Eligibility
* Do not complete a full case review
* Do not extend the Certification Period

If the change of circumstance will have an impact on eligibility such as a loss in coverage, moving from full to limited coverage, or limited to full coverage (Exception: PCR to FP due to change in income, send to TMA for review):

* A full case review is required
* Certification Period must be extended

**Note:** If the change of circumstance results in a change in payment category but not a change in coverage level (Ex: PCR to PW) a full case review **is** required.

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| **Change of Circumstance and when to complete a case review for MAGI cases** |
| The following changes may require a full case review:* Income (addition or loss)
* Additional person added per Application page
* Marital Status (includes marriage or divorce)
* Living Arrangement (non-institutional to institutional)
* Death of a spouse
 | The following changes may **not** require a full case review:* Address
* Household Composition except for marriage or divorce
* Citizenship Status
* Disability Status (send to Non-MAGI)
* Authorized Representative
* Name
 |

**101.10.02 Non-MAGI Renewals**

(Rev. 12/01/21)

The eligibility of Medicaid beneficiaries enrolled in a non-MAGI eligibility group must be redetermined at least every 12 months. The agency must make the redetermination without requiring additional information from the individual if able to do so based on the individual’s case or current information available. If the agency is able to make the redetermination without requiring additional information from the individual, the agency must notify the individual of (i) the eligibility determination, (ii) the basis for the determination, and (iii) have the individual indicate if any information in the case is inaccurate.

If the agency is unable to make the redetermination without requiring additional information from the individual, the agency must provide the individual with the following:

* A pre-populated renewal form,
* A response time of thirty (30) days from the date of the renewal form to answer and provide necessary information; and
* Notice of the agency’s eligibility decision once the review is complete.

The agency must also:

* Verify any information provided by the beneficiary;
* Reconsider the eligibility of an individual who was terminated for failure to submit a renewal form or necessary information. If an individual submits a renewal form or necessary information within ninety (90) days following the termination date, his eligibility should be considered without requiring a new application; and
* Not require an individual to complete an in-person interview as part of the renewal process.

The agency must promptly redetermine eligibility between regular renewals of eligibility whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility. The agency may consider blindness and disability as continuing until the reviewing physician/team determines that the beneficiary’s condition no longer meets the definition of blindness or disability.

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| **Extending the Certification Period when there is a Change of Circumstance**Medicaid beneficiaries are required to report changes in their circumstances to SCDHHS within 10 days. Eligibility specialists must act on those changes as they are reported. Some changes may require a case review and some changes may not. When a case review is completed, the Certification Period must be extended to one year from the last day of the month prior to the month the case is authorized.**When to extend the Certification Period**If a change of circumstance is reported within 90 days of the Certification Period end date: * A full case review must be completed
* The Certification Period must be extended

If a change of circumstance is reported within 90 days of the last case review or case approval:* Update the evidences only on the Evidence Dashboard
	+ Add required verifications
	+ Apply Changes
	+ Check Eligibility
* Do not complete a full case review
* Do not extend the Certification Period

If a change of circumstance is reported that does not impact eligibility: * Update the evidences only on the Evidence Dashboard
	+ Add required verifications
	+ Apply Changes
	+ Check Eligibility
* Do not complete a full case review
* Do not extend the Certification Period

If the change of circumstance will have an impact on eligibility such as a loss in coverage, moving from full to limited coverage, limited to full coverage or Non-MAGI to LTC (Exception: Nursing Home to HCBWS and vice versa):* A full case review is required
* Certification Period must be extended

**Note:** If the change of circumstance results in a change in payment category but not a change in coverage level (Ex: SLMB to QI) a full case review **is** required.

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| **Change of Circumstance and when to complete a case review for Non-MAGI cases** |
| The following changes may require a full case review:* Income (includes Cost of Living Adjustments)
* Resources
* Receipt of Medicare
* Marital Status (includes marriage or divorce)
* Living Arrangement (non-institutional to institutional)
* Death of a spouse
 | The following changes may **not** require a full case review:* Address
* Household Composition except for marriage or divorce
* Citizenship Status
* Disability Status
* Authorized Representative
* Name
 |

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| **Change of Circumstance and when to complete a case review for Long Term Care cases** |
| The following changes may require a case review for Long Term Care cases:* Income (includes Cost of Living Adjustment and Income Trust)
* Resources
* Receipt of Medicare
* Marital Status (includes marriage or divorce)
* Death of spouse
* Living Arrangement (institutional to non-institutional)
 | The following changes **do** **not** require a case review for Long Term Care cases:* Deductions (includes HMA, Health Insurance Premiums and Allocations)
* Household Composition except for marriage or divorce
* Citizenship Status
* Disability
* Authorized Representative
* Name
* Living Arrangement (Institutional to Institutional)
 |
| **Note:** Nursing Home or HCBWS to OSS and vice versa, a full case review **is** required. |

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**101.10.03 Processing Review Forms**

(Rev. 12/01/21)

[CFR §435.916](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.74.18&rgn=div8); [CFR §435.908](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.6.10.72.9&rgn=div8)

When a beneficiary’s eligibility is up for redetermination, the state must make that determination based on reliable information currently available to the agency. The state may not request any additional information from the beneficiary if that additional information is not necessary to make a determination.

If continuing eligibility can be approved based on available information, the agency must send a (i) notice to the beneficiary indicating the pending re-approval and (ii) form stating what information was used to approve the case. The beneficiary must review the information on the form and, if there are any inaccuracies, return a corrected version within 30 days. If form is received outside of 30-day period, it will be treated as a reported change.

If additional information is necessary, the agency must send a form pre-populated with information available to the agency to the beneficiary indicating what information is missing. The beneficiary will have 30 calendar days to provide missing information.

If necessary, an Eligibility Worker must make a reasonable effort to assist the beneficiary. Once all information is received, an Eligibility Worker must complete the review process.

Prior to making a determination of ineligibility, the agency must consider other eligibility programs for an ex parte decision. Following a determination of ineligibility, the agency must determine potential eligibility for other insurance affordability programs at the FFM. Any renewal form or notice must be accessible to persons who have limited English skills and to persons with disabilities.

Note: For PHC cases that go into review status on or after April 1, 2011, a data match will be completed with the DSS CHIP system. If the beneficiary is currently receiving SNAP (food stamps) or TANF (FI), continuing Medicaid eligibility will be determined by MEDS/ Cúram. If the beneficiary is not receiving SNAP or FI, the Eligibility Worker must complete a regular eligibility determination as stated below.

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| **Procedure for Processing Review Form****MEDS Procedure**: When a beneficiary submits a review form, the review form and any other information/ verifications received **must** be scanned into OnBase and the **“Form Received Date”** must be updated in MEDS.If additional verifications are required, the beneficiary must be given fifteen (15) days to provide any needed information. The [DHHS Form 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM%201233%20ME.pdf), Medicaid Eligibility Checklist, must be sent to the beneficiary requesting any additional information. If necessary, the Eligibility Worker must make a reasonable effort to assist the beneficiary. Once all information is received, an Eligibility Worker must complete the review process.* When setting the follow-up date in OnBase, add an additional six (6) days to allow for scanning and task creation in WLP. This provides a total of 21 days from the date of the DHHS Form 1233 is created.

For example, if a DHHS Form 1233 created on January 1 and is due on January 16, set the follow-up date in OnBase as January 22.* A task will be created in WLP either when information is returned by the individual or when the follow-up date is reached. Once a task is claimed, a worker can take the appropriate action.
* If the task was generated due to other information being scanned into the OnBase, respond to the scanned information, and put the case back into follow-up for any remaining time.
* If an applicant/beneficiary returns partial or incomplete information before the follow-up date, process the returned information, and if there is any remaining time, put the case back into follow-up.

For example, a DHHS Form 1233 is sent on January 1 with a follow-up date of January 22 in OnBase. On January 10, the applicant returns half of the requested information. The eligibility specialist will: * + Update the Documentation Template;
	+ Update any systems as appropriate; and
	+ Put the case back into follow-up with the original January 22 follow-up date.
* If the information is not returned by the follow-up date in OnBase, a task will be created in WLP so a worker can deny the application when the task is claimed.
	+ If the original follow-up date does not include the additional six (6) days to allow for scanning and task creation in WLP, put the case back into follow-up with the correct date if the date has not already passed.
* If the individual is not eligible, no additional action needs to be completed in MEDS.
* If the individual is eligible and the worker is taking action within 90 days of the closure, the existing Budget Group can be reopened using code 100. There should be no gap in eligibility
* If the individual submits the renewal form or necessary information after 90 days, then the renewal form should be used as a new application.
 |
| **Cúram Procedure**: Refer to the [MAGI Annual Review Process](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Reviews/MAGI%20Annual%20Review%20Process.pdf?csf=1&web=1&e=QQjw4V) job aid at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/) for the appropriate instructions. |

If the beneficiary fails to return the review form and/or any requested information within the 30-calendar day period and the case closes, the case can be re-opened if the beneficiary returns the review within 90 calendar days from the date of closure. If the information is received later than 90 calendar days, the review form must be treated as a re-application.

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| **Processing a Review Flow Chart** |
| Diagram  Description automatically generated |

**Exception:** Nursing Home, Waivered Services, and OSS budget groups (Payment Categories 10, 15, 33, and 85) do not close automatically. If a review is not received, MEDS will put the case in Maintenance Status. If the review is received after the case has been placed in Maintenance Status, the Eligibility Worker must treat this as a reported change and complete a redetermination.

**TMA Quarterly Reports**

* 1. For signed or unsigned reports, determine if any wages are included.
1. If any wages are included, register the report receipt date in MEDS.
2. If no wages are included, do not register the report receipt date in MEDS unless Good Cause is alleged.
	1. All TMA Quarterly Reports must be scanned into OnBase.

**101.11 Reserved for Future Use**

**101.12 Rights of Applicants/Beneficiaries**

(Eff. 01/01/14)

Any individual applying for and/or receiving assistance has certain rights and responsibilities relating to receipt of Medicaid benefits. This section describes the rights and responsibilities of applicants/beneficiaries.

**101.12.01 Opportunity to Apply**

(Eff. 01/01/14)

Any individual who requests Medicaid assistance, including those who are clearly ineligible, must be allowed to apply immediately. Eligibility Workers must make a reasonable effort to assist the applicant in establishing eligibility.

**101.12.02 Civil Rights and Non-Discrimination**

(Eff. 01/01/14)

Persons applying for, or receiving benefits or services under, any program administered by or through the SC DHHS, shall not be discriminated against in any manner. The following non-discrimination laws apply to Medicaid:

* Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin.
* Title V, Section 504 of the Rehabilitation Act of 1973, as amended, prohibits discrimination based on handicap.
* Title II, Section 202 of the Americans with Disabilities Act of 1990, guarantees equal opportunity for qualified individuals with disabilities in employment, public accommodations, transportation, public service, state and local government services and communications. This Act requires that interpreters be available for applicants/beneficiaries, if needed.
* The Age Discrimination Act of 1975 prohibits discrimination based on age.

Any individual who feels that he/she has been subjected to such discrimination may file a signed, written complaint within 180 calendar days of the alleged discriminatory act, by mailing the complaint to:

South Carolina Department of Health and Human Services

Attn: Civil Rights Division

Post Office Box 8206

Columbia, South Carolina 29202-8206

All complaints will be investigated in accordance with state and federal laws and regulations.

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**101.12.03 Confidentiality of Information**

(Rev. 10/01/13)

[CFR §431.305](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5b433b4fd4f2544aa9f64e97c6c014&node=42:4.0.1.1.2.6.15.6&rgn=div8)

The South Carolina Medicaid program will adhere to state laws and federal regulations regarding the protection of applicant’s and beneficiaries’ confidential information. Federal Regulations include Title 42, Code of Federal Regulations at Part 431 and state law includes the applicable provisions of State Regulations at SC Code Ann. R. 126-170 et seq. Information (i) obtained during the application process or (ii) contained in records of beneficiaries or former beneficiaries is confidential and must be safeguarded. Medicaid will also adhere to the Health Insurance Portability and Accountability Act (HIPAA) regulations regarding applicant/beneficiaries’ confidential information. There are two types of protected information: (i) financial and (ii) medical. Both types may be disclosed without beneficiary authorization only for purposes directly connected with the administration of the program, including:

* + - * Establishing eligibility;
			* Determining the amount of medical assistance;
			* Providing or arranging for services for a given beneficiary; and,
			* Prosecution of civil or criminal proceeding related to the administration of the State Plan.

**Protected/Safeguarded Information**

Eligibility and medical information which must be safeguarded includes, but is not limited to, the following:

**1. Eligibility information**

* Name and address of applicants/beneficiaries
* Social Security Number
* Date of Birth
* Social and economic conditions or circumstances
* Evaluation of personal information such as financial status, citizenship, residence, age and other demographic characteristics
* Information received for verifying income eligibility and amount of benefits. (Refer to Chapter 104, Appendix P)
* Information received in connection with the identification of a liable third-party resource

**2.** **Medical information**

* Medical data, including diagnosis and history of diseases or disabilities
* Medical services provided
* Medical status, psycho behavioral status, and functional ability
* Results of laboratory tests
* Medication records

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| **Note**Medical information/evaluation provided by the Department of Mental Health (DMH) and/or the Veterans Administration (VA) is not to be released to anyone without the approval of DMH and/or VA. In addition, alcohol and drug abuse information is subject to special confidentiality standards. |

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**101.12.04 Release of Eligibility Information**

(Eff. 10/01/13)

Disclosure of eligibility/financial information without the permission of the applicant/ beneficiary should only occur for purposes directly connected with the administration of the program and then only to persons, agencies, and entities with comparable confidentiality standards. Listings of Medicaid applicants/beneficiaries may not be released to anyone without the consent of SC DHHS.

As required by federal law, all application data will be automatically sent to the Federally Facilitated Marketplace (FFM) for those applications who contain an individual who is not eligible for Medicaid but is assessed to be potentially eligible for other affordable insurance programs.

Application data will also be automatically received from the FFM for any individual or their family who is assessed potentially Medicaid eligible by the FFM.

Eligibility information may be automatically sent to the FFM for any applicant who requests eligibility assessment or determination by either the FFM or SC DHHS.

Medical providers who are enrolled in the South Carolina Medicaid program may verify a beneficiary’s eligibility for Medicaid benefits for the previous 12 months by utilizing the Medicaid Interactive Voice Response System (IVRS) or a Point of Sale (POS) device. SC DHHS has contracted with GovConnect to maintain the IVRS.

To access IVRS, medical providers must use a touch-tone phone to call the toll-free telephone number: 1-888-809-3040, and enter their six (6)-character Medicaid Provider Identification. Medical providers will be prompted to enter the related Dates of Service and one of the following beneficiary identifiers:

* Medicaid Health Insurance Number,
* Social Security Number, or
* Full name and date of birth.

The system then submits the data provided and plays the beneficiary eligibility information back to the medical provider over the phone to include beneficiary special program status; Medicare coverage, third-party insurance coverage, and service limitations/visit count information. This service is provided 24 hours per day, seven (7) days per week in a real time environment, and there is no charge to the medical provider for this service.

In addition, on the back of the Healthy Connections (Medicaid) Insurance Card is a magnetic strip that may be utilized in POS devices to access information regarding Medicaid eligibility, third-party insurance coverage, beneficiary special programs, and service limitations 24 hours per day, seven (7) days per week in a real time environment. There is a fee to the medical provider for this service.

Medical providers that have contracted with the SC DHHS to provide a Sponsored Medicaid Worker must have a [SC DHHS Form 934 ME](http://medsweb.scdhhs.gov/EligibilityForms/FM%20934.pdf), Appointment of Agent for Medicaid Determination and Appeal Process, signed by the applicant/beneficiary to receive information concerning an application/review or appeal being processed by a worker for individuals in the facility.

Organizations who have signed a Memorandum of Agreement with SC DHHS to act as an intake site, must also use the SC DHHS Form 934 ME in order to receive information from the Eligibility Worker regarding the applicant/ beneficiary during the Medicaid application/review and/or appeal process.

**101.12.05 Release of Medical Information**

(Eff. 01/01/14)

Generally, release of medical information must be authorized by the patient/beneficiary.

Beneficiary consent should be obtained before responding to a request for information from an outside source. Consent should include a description of the information to be released and identification of the receiving entity. The consent should be signed by the beneficiary or responsible party and witnessed. Only the information described may be released and only to the entity described.

Emergency requests for medical information should be forwarded to Eligibility, Enrollment and Member Services at SC DHHS. If the Eligibility Worker is instructed that, due to an emergency, prior consent is not possible, the beneficiary or responsible party must be notified as soon as possible after the information is released.

**101.12.06 Release of Application/Case Information**

(Eff. 11/01/15)

The applicant may authorize SC DHHS to release information about his or her application/case to an individual or an organization by completing the appropriate section on the SC DHHS Form 1282. Unlike the Authorized Representative, this section only grants the individual or organization permission to receive information on the applicant’s application/case and not permission to act on behalf of the applicant.

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| **Procedure for Recognizing an Individual or Organization with Permission to Receive Application/Case Information**  |
| If the DHHS Form 1282 ME is submitted at the time of application, then the Form 1282 should be processed with the Application. If the Form 1282 ME is submitted after the application is submitted, then scan the Form 1282 into OnBase as a MEDS-Member Verification trailing document. The worker should then enter the individual or organization’s information into notes in MEDS and on the Application Tracking Form in OnBase.**NOTE:** If the SC DHHS Form 1282 is submitted after the application, it should be mailed to:SC DHHS – Central MailP O Box 100101Columbia, SC 29202-3101 **NOTE:** Until the signed DHHS Form 1282 ME or other legal authorization (such as a Power of Attorney) is received, application information cannot be shared with anyone except the applicant, a current spouse, or the parent of a minor child who is shown on the application.If an Applicant/Beneficiary has two or more individuals or organizations with permission to receive application/case information, staff should enter a note in MEDS and OnBase on the Application Tracking Form with the additional individual or organization’s information. **Cúram Procedure** The appropriate procedure may be found in the [Authorized Representative Process](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Authorized%20Representative%20Process.pdf?csf=1&web=1&e=TfM4zP) job aid at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/). |

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| Nature of Provider Request | Valid Form 1282 Needed? |
| Application status | Yes |
| Information needed to process an application/Copy of Form 1233 Checklist | Yes |
| Verification that application has been submitted  | Yes |
| Retroactive coverage status | Yes |
| Requests for retroactive coverage | Yes |
| Appeal status | Yes |
| Information regarding an individual’s appeal | Yes |
| Review status | Yes |
| Information regarding an individual’s annual review | Yes |
| Check eligibility for specific date of service (Provider must have either a Medicaid ID# OR a date of birth and either the individual’s name or Social Security Number) | No |
| Form 945 needed | No |
| Provider wants to provide information to deem an infant (complete Form 1716 by phone) | No |
| Completed Form 1716 with infant Medicaid ID# | No |
| Questions about the application process or forms (not for a specific individual) | No |

**101.12.07 South Carolina Health Information Exchange (SCHIEx)**

(Eff. 01/01/14)

SCHIEx (SKY-eks), the South Carolina Health Information Exchange, gives healthcare providers, such as doctors and hospitals, the ability to view medical information on Medicaid beneficiaries. The information available includes medications, diagnosis, procedures, and common problems. Having this information will help the healthcare provider coordinate care for better continuity and quality, as well as assist with controlling cost. This clinical data is collected from 10-years of paid SC Medicaid claims, as well as information shared from participating providers' electronic medical record (EMR) systems.

Medical Information for Medicaid beneficiaries will be included in SCHIEx, but participation is not mandatory. A beneficiary can opt-out, or choose not be included, by contacting the Resource Center at 1-888-549-0820. If a beneficiary decides not to participate, a healthcare provider will not be able to see any of that person’s medical information. Individuals who have opted-out can later opt-in by contacting the Resource Center.

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**101.12.08 Request for Information on Medicaid Beneficiaries from External Parties**

(Rev. 01/01/14)

The Attorney General’s Medicaid Fraud Control Units (provider and beneficiary) are directly involved in the administration of the Medicaid program and handle cases under agreements with the Division of Program Integrity. Therefore, SC DHHS is committed to cooperating with these units of the Attorney General’s office in providing information on beneficiaries who receive Medicaid.

SC DHHS is not authorized to disseminate information directly to external parties other than those units of the Attorney General’s office. Any requests coming from other entities such as: The State Law Enforcement Division (SLED), The Federal Bureau of Investigations (FBI), Drug Enforcement Administration (DEA), The U.S. Attorney’s office, other units of the Attorney General’s Office or the U.S. Marshal’s office, must be referred by the local eligibility office to the Office of General Counsel (OGC) within SC DHHS.

Upon receipt of the request, the Office of General Counsel will review the request and advise the local office. For any requests that are deemed questionable, local offices may contact the Office of General Counsel.

**101.12.09 Receipt of Subpoena to Request Release of Information to Courts**

(Eff. 01/01/14)

If confidential information is requested through a subpoena, the Eligibility Worker should immediately contact the Office of General Counsel at SC DHHS. A copy of the subpoena must be faxed to the Office of General Counsel, which will instruct the Eligibility Worker regarding the action to be taken.

**101.12.10 Confidentiality Release of Aggregate Data and Information for Audits**

(Rev. 01/01/14)

General or statistical information such as total expenditures, the number of beneficiaries served and other information that cannot be identified with a specific person may be released. Protected information may be released to state and federal auditors performing bona fide audits.

**101.12.11 Right to Appeal and Fair Hearing**

(Rev. 07/01/22)

At the time of any action affecting an Applicant or Beneficiary’s Medicaid application or benefits, the agency must inform the individual of:

* The right to request a fair hearing;
* The ways to request a fair hearing;
* The right to be represented by the person of their choice at the hearing. They may represent themselves or designate someone as a representative, such as a lawyer, relative, friend, or another spokesman.

**NOTE:** During a hearing, an applicant/beneficiary can designate anyone attending to represent them. A written statement is unnecessary as long as the applicant/beneficiary is present and can give permission.

If the applicant/beneficiary is not present, a designated individual must be authorized either with a valid DHHS Form 1282 or other legal documentation, such as a Power of Attorney or Certificate of Appointment for a Guardianship or Conservatorship.

The agency must grant the opportunity for a fair hearing to any Applicant/Beneficiary who requests it because:

* His/her claim for medical assistance is denied or is not acted upon with reasonable promptness;
* He/she believes that the agency has taken an action erroneously; and/or
* He/she believes a nursing facility has erroneously determined that he/she needed to be transferred or discharged.

The agency will not grant a hearing when the sole issue is a federal or state law requiring an automatic change which adversely affects some or all beneficiaries.

The applicant or beneficiary must submit the appeals request to the South Carolina Department of Health and Human Services (SCDHHS) Division of Appeals and Hearings within thirty (30) calendar days of the date on the Notice of Action to be a valid appeal. The applicant or beneficiary can provide a good cause for an untimely filing for the Hearing Officer to consider continuing with the appeal request. The following methods are available to submit a request:

* Appeals Website [msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/),
* Email [appeals@scdhhs.gov](appeals%40scdhhs.gov),
* Fax (803)-225-8251
* Phone (888) 549-0820
* Mail SCDHHS Division of Appeals and Hearings

PO Box 8206

Columbia, SC 29202

The faxed or mailed appeal request should take the form of either a letter or a signed DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant or Beneficiary.

Information about the appeal process and what should be included in a request for appeal can be found at the following link: [msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/).

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| **Procedure to Request a Fair Hearing** |
| 1. The request for a fair hearing can be made in writing (online, email, fax, or mail)
2. Intake for a telephonic appeal request is accepted through the Member Contact Center at (888)-549-0820.
3. The request can also be made in-person by coming into a county SCDHHS location. If the Applicant/Beneficiary or their authorized representative comes to a county SCDHHS location to ask for an appeal, the Eligibility Worker should complete Part I of [DHHS Form 3260](https://medsweb.scdhhs.gov/EligibilityForms/FM%203260%20ME.pdf), Request for Fair Hearing for Medicaid Applicant/Beneficiary and provide the form to the Applicant/Beneficiary to complete and return, or instruct the individual to submit his own written appeal request or refer him to the Appeals website ([msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/)) and note the telephonic appeal option.
4. The request must be made within 30 calendar days from the date on the Notice of Action. If the request is received after 30 days, the Hearing Officer will decide if the appeal should continue or be dismissed. A request for a fair hearing by mail is timely if postmarked by the thirtieth (30th) calendar day following receipt of the notice.
5. Beneficiaries who submit their own written appeal request must be informed of the option to continue Medicaid benefits during the appeal process.
6. Appeal requests are sent directly to the Division of Appeals and Hearings. The Division of Appeals and Hearings will notify the Eligibility Determination Respondent Team of the appeal filed and documents needed.
7. If the Applicant/Beneficiary requests an appeal by email or letter, DHHS Form 3260 does not need to be completed.
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| **Procedure for online request** |
| **Appeals Request**1. The applicant/beneficiary or authorized representative submits a request through the website: [msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/).
2. The appeals request is automatically sent to the Division of Appeals and Hearings

**Appeals Withdrawal Request**1. The applicant/beneficiary or authorized representative submits a request through the website: [msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/).
2. The appeals request is automatically sent to the Division of Appeals and Hearings.
 |
| **Procedure for Telephonic Appeal Request and Appeal Withdrawal** |
| **Appeals Request**1. The Member Contact Center will receive the call from the applicant/beneficiary or authorized representative requesting to appeal the case.
2. The Member Contact Center will complete the online Appeals Request Form with the applicant/beneficiary and submit the form to the Division of Appeals and Hearings.
3. Member Contact Center obtains a verbal signature for the appeal.
4. Member Contact Center checks the indicator when the signature file is obtained for the verbal signature and stores the signature file. The file will be available upon request.

**Exception:** When an appeals request is received via a telephonic request in to a local LEP Office the eligibility worker will:* Provide the number to the Member Contact Center if the applicant/beneficiary or authorized representative wants to complete a telephonic request; or
* If the applicant beneficiary declines to complete the telephonic request, the eligibility worker will complete Part I of DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant/Beneficiary and send the form to the Applicant/Beneficiary to complete and return, or instruct the individual to submit his own written appeal request or refer him to the Appeals website ([msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/)).

**Appeals Withdrawal Request** 1. The member services representative will complete the assigned form with the applicant/beneficiary. A verbal signature recording is obtained.
2. The Member Contact Center will submit the form to the Division of Appeals and Hearings.
 |
| **Procedures for In-person Appeal Request** |
| **Appeals Request**1. The eligibility worker will complete Part I of DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant/Beneficiary and give the form to the applicant/beneficiary or the authorized representative.
2. The applicant/beneficiary or the authorized representative will complete the form and return the form to the eligibility worker.
3. The eligibility worker must reopen the eligibility if continued benefits were requested by the beneficiary. (See MPPM 101.12.10A, Continuation of Benefits during Appeals Process.)
4. The eligibility worker will date stamp and email the DHHS Form 3260 to the Division of Appeals and Hearings ([appeals@scdhhs.gov](appeals%40scdhhs.gov)).

**NOTE:** If the applicant/beneficiary or the authorized representative decides to complete the DHHS Form 3260 at home, the eligibility worker will provide the options for returning the form to the Division of Appeals and Hearings (mail or fax).**NOTE:** If the applicant/beneficiary does not want to complete the written version of the DHHS Form 3260, the eligibility worker will provide the applicant/beneficiary or authorized representative with the website and the telephone number to make a verbal request.**Appeals Withdrawal Request** 1. The applicant/beneficiary or authorized representative will complete a DHHS Form 1766, Declaration Statement, or a written letter requesting to withdraw the appeal case. The applicant/beneficiary must sign the request.
2. The eligibility worker will date stamp the withdrawal request then email the withdraw request to the Division of Appeals and Hearings.
 |
| **Procedure for written request via letter or DHHS Form 3260 (fax, email, or mail)** |
| **Appeals Request**The applicant/beneficiary or authorized representative will send a written letter or DHHS Form 3260 via fax, email or mail to the Division of Appeals and Hearings. NOTE: If CDM receives the request, do not scan the documents into OnBase. Stamp the documents with the date received by CDM and mail the documents to the Division of Appeals and Hearings at SCDHHS Division of Appeals and Hearings, PO Box 8206, Columbia, SC 29202.**Appeals Withdrawal Request** The applicant/beneficiary or authorized representative will mail or fax a written letter or send an email requesting to withdraw the appeal case directly to the Division of Appeals and Hearings. The applicant/beneficiary must sign the written request. |
| **Eligibility Procedure to Process an Appeal** |
| 1. The Division of Appeals and Hearings sends a copy of the appeal request via email to the Eligibility Respondent Coordinator Manager or Supervisor
2. The Eligibility Respondent Coordinator Manager/Supervisor places the information in OnBase and assigns the case to an Eligibility Respondent Coordinator (ERC) in the ERC Database. A response timeframe is entered in the database as indicated in correspondences from the Division of Appeals and Hearings. The email from the Division of Appeals and Hearings is forwarded to the assigned ERC to review the appeals case.
3. The assigned ERC must reopen the eligibility if continued benefits were requested by the beneficiary. (Refer to MPPM 101.12.10A, Continuation of Benefits during Appeals Process.)
4. If an eligibility error is suspected, the ERC notifies his/her manager/supervisor that an Eligibility Quality Assurance (EQA) case review is needed. The manager/supervisor notifies EQA of the needed review. EQA reviews the case then notifies the EDR manager/supervisor of the review outcome. The manager/supervisor communicates EQA review outcome with the assigned ERC.

If an eligibility error is confirmed, the case is sent to the Escalations Team for processing. A DHHS Form 1233 will be sent to the applicant/beneficiary if additional information is needed. The applicant/beneficiary has 15 days to return the requested information.1. If no additional information is needed, the ERC will complete the appeals summary packet and send it to the Division of Appeals and Hearings by secure email for standard documents or by SCDHHS drop (https://drop.scdhhs.gov) for large documents. A hard copy must be mailed to the applicant/beneficiary or authorized representative. The packet must include at minimum the following information:
* DHHS Form 3317, Appeal Summary,

Note: An Appeals Summary is a brief explanation of the reason for the appeal, the relevant facts, and the policy/law that served as the basis for the determination* DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant or Beneficiary, or a written appeal request,
* Application/Review form,
* All Notices of Action, manual notices, and/or the Letter of Correction,
* DHHS Form 1282, Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals—if the appeal was request by a person other than the Applicant/Beneficiary.
* Verifications used in the decision
	+ For example, when an application is denied due to excess income, include income verification. If the case is closed due to excess resources, include verification of the countable resources.
* Applicable sections of the MPPM in effect at the time of the decision (if the appeal is not withdrawn)
* If the applicant/beneficiary requests to withdraw an appeal, the ERC will only send the appeal request and withdrawal request to the Division of Appeals and Hearings.
* The ECR will upload the appropriate documents to OnBase as an “MEDS-Appeal Documents”. Select “No” to trailing.

**IMPORTANT:** If an Appeal Summary packet cannot be produced by the indicated time, a request for an extension must be made to the hearing officer and petitioner/ applicant/AR.**NOTE:** Eligibility workers should continue to process cases based on current policy and procedures even when the case is in the appeal process. |
| **OnBase Procedure** |
| All documents associated with the appeal, including new verifications, workbooks, emails and documents, such as Orders to Produce, Interlocutory Orders, and decisions, must be scanned into OnBase. For Orders to Produce, Interlocutory Orders, and decisions, select “MEDS-Appeal Documents” as the document type. Select “no” in the trailing documents field.  |
| **MEDS/Cúram Procedure** |
| A note must be created in MEDS or Cúram documenting actions taken during the appeal process, such as an appeal was requested, an appeal packet was sent to the Petitioner and the Division of Appeals and Hearings, and a new decision was made.A note must be created in MEDS or Cúram about any emails and documents, such as Orders to Produce, Interlocutory Orders, and decisions, scanned into OnBase.The Documentation form in OnBase must also be updated with any actions made to the case and emails or documents received. |

**101.12.11A Continuation of Benefits during the Appeal Process**

(Rev. 06/01/21)

If SCDHHS has met the advance notice requirements of MPPM [101.09.03](#MPPM_101_09_03), the agency may not terminate or reduce Medicaid benefits for a Beneficiary who submits a written request for a fair hearing before the date of adverse action until a decision is rendered after the hearing unless:

* It is determined by the Hearing Officer that the sole issue is one of Federal or State law requiring an automatic change which adversely affects some or all beneficiaries; **and**
* The agency promptly informs the Beneficiary in writing that benefits are to be terminated or reduced until the hearing decision is issued.

SCDHHS must reinstate and continue benefits until a decision is made by the Hearing Officer if the following three conditions are met:

* The adverse action is taken without the advance notice required under MPPM [101.09.03](#MPPM_101_09_03);
* The beneficiary requests a hearing within 10 calendar days from the date that the individual receives the notice of action. The date on which the notice is received is considered to be 5 calendar days after the date on the notice unless the beneficiary shows that he or she did not receive the notice within the 5-day period; **and**
* SCDHHS determines that the action resulted from other than the application of Federal or State law requiring an automatic change which adversely affects some or all beneficiaries.

If the request for a fair hearing is received within 10 calendar days after the date of the adverse action, SCDHHS may reinstate benefits. The decision to reinstate benefits in this instance is based on the specifics of the case and at the discretion of the Deputy Director of Eligibility, Enrollment, and Member Services or his/her designee. If reinstated, the benefits must continue until the decision is made by the Hearing Officer, unless the Hearing Officer determines that the sole issue is one of Federal or State law requiring an automatic change that adversely affects some or all beneficiaries.

If a Beneficiary’s whereabouts are unknown, or if the Notice of Adverse Action is returned by U.S. Postal Mail and cannot be forwarded, any discontinued services must be reinstated if his or her whereabouts become known during the time he or she is eligible for services.

Only closed cases may receive continued or reinstated benefits. The assigned Eligibility Specialist must take the appropriate steps in MEDS or Cúram to reopen the benefits.

The Beneficiary can decline the continuation of benefits on the DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant or Beneficiary, or by other written request, such as a letter, fax, or email. If the Beneficiary declines continued benefits in writing, the Eligibility Specialist should not reopen the benefits. If the beneficiary declines continued benefits in writing after the case has been reopened, the Eligibility Respondent Coordinator must immediately close the case using the appropriate Reason Code. Either a system generated, or manual closure notice must be sent.

The assigned Eligibility Specialist must explain to the Beneficiary that if the Hearing Officer rules in support of the decision made by SCDHHS, any payments made to providers, including Managed Care Organizations, for services received by the Beneficiary during this period are subject to repayment from the Beneficiary. If the Hearing Officer rules in support of the agency’s decision, the assigned Eligibility Respondent Coordinator must prepare an overpayment summary in accordance with policy as outlined in MPPM [101.16.01](#MPPM_101_16_01).

Regardless of whether the request for an appeal is submitted timely, Medicaid benefits cannot be approved for an Applicant unless the decision is reversed by the Hearing Officer.

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| **Appeal Examples** |
| * Ringo Starr receives a closure notice dated January 15 indicating his Medicaid eligibility will end effective February 1. His request for a fair hearing is received on January 31. Unless he declines, Ringo will receive a continuation of Medicaid benefits because his request is received before the date of the adverse action.
* Kendrick Lamar receives a closure notice dated January 15 indicating his Medicaid eligibility will end effective February 1. His request for a fair hearing is received on February 9. Because his request was made within ten days of the date of the adverse action, Kendrick may receive a reinstatement of Medicaid benefits based on the specifics of the case and at the discretion of the Eligibility Respondent Coordinator assigned to the appeal.
* Miles Davis received a notice on January 20 dated January 15 indicating his Medicaid eligibility will end effective January 16. His request for a fair hearing is received on January 29. If the adverse action did not result from the application of Federal or State law requiring an automatic change which adversely affects some or all beneficiaries, Miles will receive a reinstatement of Medicaid benefits because SCDHHS did not provide enough advance notice (which is at least 10 days before the action) and his request was received within 10 days from when Miles received the action.
 |

**101.12.11B Interlocutory Order, Order to Produce, Pre-Hearing Conference Order**

(Rev. 04/01/21)

The Hearing Officer in the Division of Appeals and Hearings may issue an Interlocutory Order, an Order to Produce, or a Pre-Hearing Conference Order. These orders request that either additional actions be taken, or additional information be provided. The orders may be addressed to any or all of parties involved, including the applicant/beneficiary, their representative, and/or the assigned Eligibility Respondent Coordinator.

The order will have specific instructions about what actions each party must take. The Hearing Officer will require a response to the Order by a specified date. If a response is not provided, the appeal may be dismissed, or the decision reversed. If a response is received, the Hearing Officer will determine the next appropriate action.

**101.12.11C Pre-Hearing Conference**

(Rev. 04/01/21)

A Pre-Hearing Conference may be initiated by the assigned Eligibility Respondent Coordinator, a Pre-Hearing Conference Order, issued by the Hearing Officer, or by request of the Applicant/Beneficiary or his/her representative. The Pre-Hearing Conference does not nullify the Applicant/ Beneficiary’s right to a hearing.

A Pre-Hearing Conference may be used to discuss:

* + - Continued benefits,
		- How the decision was made,
		- If the decision has been modified,
		- If the Applicant/Beneficiary’s circumstances have changed,
		- The issues being appealed,
		- Additional information needed to change or continue with the eligibility determination process,
		- The appeal process, and
		- Whether the appellant wishes to continue with the appeal process.

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| **Prehearing Conferences** |
| 1. Prehearing Conferences are ordered by the Hearing Officer. (Refer to MPPM 101.12.11 C) Adhere to the timeframes indicated in the order. The order will outline which party is to initiate contact. If the Respondent is to initiate contact, follow the actions below:
2. The assigned Eligibility Respondent Coordinator must contact the applicant/ beneficiary or their representative as outlined in the order via phone, email, or mail to schedule a pre-hearing conference.
3. Hold the prehearing conference as scheduled. During this conference, the assigned Eligibility Respondent Coordinator should discuss:
	* + Continued benefits,
		+ How the decision was made,
		+ If the decision has been modified,
		+ If the Applicant/Beneficiary’s circumstances have changed,
		+ The issues to be appealed,
		+ Additional information needed to change or continue with the eligibility determination process,
		+ The appeal process, and
		+ Whether the Applicant/Beneficiary wishes to continue with the appeal process.
			- The assigned Eligibility Respondent Coordinator should ask for a written withdrawal if the Applicant/Beneficiary does not wish to continue with the appeal process. This can be sent via online, email, fax, mail or verbally requested through member services.
4. If the order is for the Petitioner to contact the Respondent (ERC), the ERC should wait until the deadline for the conference. If contact is not received from the Petitioner by the deadline, the ERC should submit a Prehearing Conference Summary/Motion to Dismiss. This must be submitted to the Hearing Officer and the Petitioner.
 |

If the decision appears to be incorrect following the Pre-Hearing Conference, the assigned Eligibility Respondent Coordinator will correct the case and notify the Applicant/Beneficiary or their representative via a new Notice of Action a corrected appeal packet must be sent to the Division of Appeals and Hearings and the Applicant/ Beneficiary or their representative.

**101.12.11D Notification of Hearing**

(Rev. 04/01/21)

Staff in the Division of Appeals and Hearings will notify the Applicant/Beneficiary at least 30 calendar days before the scheduled hearing date unless an expedited hearing is requested. The Notice of Hearing will include the following information:

* The time and place of the hearing,
* The subject of the hearing,
* The hearing procedures,
* The Applicant/Beneficiary’s right to present written evidence, testimony, and to call witnesses,
* The Applicant/Beneficiary’s right to review the case file in advance of the hearing,
* The name of the appropriate person to notify in the event the Applicant/Beneficiary or designated representative cannot keep the scheduled appointment, and
* A statement indicating that the appeal summary will be forwarded to the individual by the assigned Eligibility Respondent Coordinator, who should be contacted if the appeal summary is not received.

A copy of the notice is also sent to the assigned Eligibility Respondent Coordinator.

**101.12.11E Hearing Participants and Hearing Format**

(Rev. 04/01/21)

A Hearing Officer from the Division of Appeals and Hearings conducts the hearing. Individuals who have taken part in the decision may not conduct the hearing or take part in the final decision-making process. The following persons will be present at the hearing:

* Petitioner – The Applicant/Beneficiary making the request for a hearing and/or his representative.
* Respondent – SCDHHS, as the State Medicaid Agency, is the Respondent. The assigned Eligibility Respondent Coordinator will appear for the Respondent.
* Respondent’s Agent – The Respondent’s Agent may include, but is not limited to, the Department of Vocational Rehabilitation, the Department of Disabilities and Special Needs, etc.

In general, the hearing’s format begins with a statement of issue, followed by a period of testimony, summation, and the conclusion of the hearing.

**101.12.11F Group Hearings**

(Rev. 08/01/14)

A group hearing on two or more appeals may be held under the following circumstances:

* + - * The issue is confined solely to state policy or a change in state policy, and
			* Each Applicant/Beneficiary is permitted to present his own case or have his case presented by a representative.

All policies and procedures governing hearings apply to group hearings. Once a decision is rendered, each Applicant/Beneficiary will receive an individually written decision concerning his appeal.

**101.12.11G Decision**

(Rev. 04/01/21)

The Division of Appeals and Hearings will make the final decision on the appeal within 90 calendar days of the date the initial request was received, if possible. The Hearing Officer will review the record in its entirety and make a decision. The decision will be issued in writing and will set forth the issues, relevant facts presented, pertinent provisions in law, regulations, agency policy, and reasoning that led to the decision.

Once the decision is mailed by the Division of Appeals and Hearings to all responsible parties, the assigned Eligibility Respondent Coordinator shall implement the directives of the decision.

**101.12.11H Order of Remand**

(Rev. 05/01/22)

The Hearing Officer in the Division of Appeals and Hearings may issue an Order of Remand. The Order of Remand is a final decision that directs the agency to perform certain actions. If an Order of Remand is received from the Hearing Officer, the assigned Eligibility Respondent Coordinator should follow the directives found under the "ORDER" section of the Order of Remand.

The Hearing Officer may direct the agency to make a new eligibility determination. A new Notice of Action must be issued by an Eligibility Specialist. The Applicant/Beneficiary has the right to appeal the new decision.

**101.12.11I Order of Dismissal**

(Rev. 02/01/16)

The Hearing Officer in the Division of Appeals and Hearings may issue an Order of Dismissal, if the Applicant/Beneficiary:

* Submits a written withdrawal request,
* Fails to appear at the scheduled hearing without good cause,
* Fails to provide the Hearing Officer with an error of fact or law that could possibly reverse the agency’s decision, or
* Fails to provide the Hearing Officer with good cause for failing to provide a timely appeal.

The Order of Dismissal is a final decision.

**101.12.11J Appellate Review**

(Rev. 02/01/16)

Any party has the right to petition for further review of a final decision, pursuant to the Administrative Procedures Act, SC Code Ann. Section 1-23-310, et seq. (1976, as amended). In accordance with the Rules of Procedure for the SC Administrative Law Judge Division, the request from the petitioner must be made within 30 calendar days of receipt of the final decision and should be directed to:

Administrative Law Court

1205 Pendleton Street

Edgar Brown Building – 2nd Floor

Columbia, South Carolina 29201

If an appeal to the Administrative Law Court is filed, the Applicant/Beneficiary or their representative should send a copy of the petition to Office of General Counsel at the same time of the appeal.

**101.13 Responsibilities of Applicants/Beneficiaries/Agency**

(Eff. 01/01/14)

**101.13.01 Applicants/Beneficiaries**

(Eff. 01/01/14)

Medicaid applicants/beneficiaries have the following responsibilities:

* **Provide Complete and Accurate Information**

Any person applying for and/or receiving assistance is required, by law, to provide complete and accurate information about his circumstances and others in whose behalf he/she has applied. Penalties are imposed for making false statements and misrepresentation of material facts, concealing or failing to disclose information with fraudulent intent, and converting benefits intended for use of one person to another.

* **Cooperation**

The applicant/beneficiary is expected to assist in the eligibility determination process by obtaining information (verifications or documentation) necessary to determine eligibility.

* **Report Changes**

The applicant/beneficiary is required to report any changes in circumstances that may affect eligibility. Such changes must be reported within ten (10) calendar days of the change. Failure to do so may constitute willful withholding of information.

* **Repayment**

A beneficiary must repay the amount paid by Medicaid for services rendered during a period of ineligibility due to failure to report changes or to provide accurate information.

**101.13.02 Agency**

(Eff. 01/01/14)

As employees of SC DHHS, eligibility staff will be committed to the following agency goals:

* To provide a benefit plan that improves member health, is evidence-based and market-driven;
* To provide a credible and continually improving eligibility process that is accurate and efficient; and
* To provide administrative support at the best possible value to ensure programs operate effectively.

To achieve this goal, staff will adhere to certain standards that will reflect positively on the agency as a whole, as well as, promote its mission to use the available resources to ensure the health and well-being of every South Carolinian.

With this in mind, employees will commit to:

* Respectful, patient, responsible customer service;
* Effective, cooperative teamwork;
* The highest standards of ethical and professional conduct;
* Competency in the function to which staff have been assigned; and
* A willingness to respond positively to the inevitable changes that occur in Medicaid policy.

**101.14 Beneficiary Lock-In Program**

(Rev. 04/01/15)

One intervention used by the Department of Health and Human Services to help identify and prevent prescription drug abuse and its harmful effects is the Beneficiary Lock-In Program. This is a statewide program that reviews pharmacy utilization data with a screening tool that helps identify beneficiaries at risk of inappropriate or unsafe prescription drug use, especially narcotics and other controlled substances. When beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Pharmacy Lock-In Program to monitor their drug utilization and to require them to utilize one designated pharmacy. This program encompasses beneficiaries receiving services directly from SCDHHS under its fee-for-service program as well as those enrolled with a Managed Care Organization.

**101.14.01 Beneficiary Lock-In Program Selection Criteria**

(Rev. 04/01/15)

The Division of Program Integrity manages a Beneficiary Lock-In Program that screens all Medicaid members against clinically-vetted criteria designed to identify drug seeking behavior and inappropriate use of prescription drugs. The Beneficiary Lock-In Program addresses issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. The Division of Program Integrity reviews beneficiary claims data in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program to monitor their drug utilization and to require them to utilize one designated pharmacy.

Beneficiaries who are enrolled in the Lock-In Program with an effective date of October 1, 2014, and forward will remain in the program for two years. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The program also has provisions that allow the beneficiary to obtain emergency medication and/or go to another pharmacy should the first pharmacy provider be unable to provide the needed services.

**101.14.02 Beneficiary Lock-In Program Procedures**

(Rev. 04/01/15)

On a quarterly basis, the Division of Program Integrity screens all Medicaid-enrolled beneficiaries (with some exceptions) against multiple criteria. These criteria are primarily based on claims data and show the number of pharmacies and physicians used by the beneficiaries over the past 6 – 12 months, the number and type of drugs prescribed for them, the beneficiaries’ diagnoses, and other potential risk factors. These criteria are clinically vetted by SCDHHS and managed care pharmacy and medical directors. All beneficiaries are screened, including those enrolled with a Medicaid MCO, with the following exceptions:

* Hospice patients
* Nursing home patients
* Children under age 16 and who are medically fragile, severely disabled, or are in a Medicaid waiver program.

SCDHHS can revise these criteria as needed. Lock-In candidates can also be identified from other sources, such as complaints received on the Fraud Hotline, Managed Care Organizations, physicians, and other sources.

Once a beneficiary has been identified for Lock-In, the Department of Recipient Utilization will:

* Send via Certified Mail a notification letter informing the beneficiary that they will be placed in the Medicaid Lock-In Program and providing them the opportunity to choose a pharmacy from which they will receive all their Medicaid prescriptions while in the program. The letter will specify the pharmacy that the beneficiary has been assigned to, but also give the beneficiary the option of choosing a different pharmacy and will describe the beneficiary’s appeal rights. The beneficiary has twenty (20) calendar days to request a change from the pre-selected pharmacy.
* After the twenty (20) day period SCDHHS will send a letter to the pharmacy selected to inform them of the beneficiary lock-in.
* If the beneficiary does not select a pharmacy within twenty (20) calendar days of the date of the letter, the lock in pharmacy will default to the one pre-selected.
* Division of Hearings and Appeals will be contacted before the beneficiary is locked in to ensure they have not filed an appeal.
* SCDHHS will concurrently inform Magellan of the beneficiaries locked-in and the selected pharmacies via MMIS data input.

If the beneficiary requests a copy of their Detailed Claims Report (DCR) in order to respond to the lock-in notification, this will be promptly provided by SCDHHS. The pharmacy provider selected will be notified of the lock-in and has ten (10) days to respond to allow adequate time for selection of another provider should the first provider determine they cannot provide the needed services.

The Division of Program Integrity, Department of Recipient Utilization, will monitor the beneficiary’s pharmacy use while in lock-in. Information regarding any beneficiaries identified for lock-in may also be provided to the SCDHHS medical director and/or pharmacy director for clinical review.

Pharmacy providers will be notified of the beneficiary pharmacy restriction via the Magellan point-of-sale (POS) system. The Magellan POS system will cause the denial of any claims for pharmacy services submitted by any provider other than the provider selected by the beneficiary.

A similar process will be followed by the Managed Care Organizations for their members who are identified for the Pharmacy Lock-in Program. SCDHHS will manage the process for fee-for-service beneficiaries; the respective MCOs will manage the process for members enrolled in their plans. The Department will refer the members selected as eligible lock-in candidates to their respective MCOs for pharmacy lock-in. Once the SCDHHS identifies members eligible for the Pharmacy Lock-in Program to the MCO, the MCO shall conduct a second review to identify any members that should not be in the program due to complex drug therapy or other case management needs.

The MCO shall have a process at the point-of-sale to “lock-in” the member to the chosen pharmacy, therefore denying claims from pharmacy providers other than the designated pharmacy.

Application of this rule will not result in the denial, suspension, termination, reduction, or delay of medical assistance to any beneficiary. As required by 42 CFR431 Subpart E, any Medicaid beneficiary who has been notified in writing by SC DHHS of a pending restriction due to misutilization of Medicaid services may exercise his/her right to a fair hearing, conducted pursuant to R126-150 et. Seq. (Refer to MPPM [101.12.10](#MPPM_101_12_10))

If a beneficiary moves, he/she can request to change the Lock-In pharmacy to one more conveniently located. Other reasons for a change of pharmacy may be considered. However, if a beneficiary changes from one managed care plan to another during the course of the two-year lock-in period, they remain in the Lock-in program regardless of which MCO is paying for the beneficiary’s medical care.

**101.15 Fraud**

(Eff. 10/01/05)

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

South Carolina state law at Section 43-7-70 defines beneficiary fraud and the penalties as they relate to the South Carolina Medicaid program. It is unlawful for:

* A person to knowingly and willfully make, or cause to be made, a false statement or representation of material fact on an application for assistance, goods or services under the state's Medicaid program when the false statement or representation is made for the purpose of determining the person's eligibility for Medicaid.
* Any applicant, beneficiary or other person acting on his behalf to knowingly and willfully conceal or fail to disclose any material fact affecting the initial or continued eligibility of the applicant/beneficiary for Medicaid.
* A person eligible to receive benefits, services or goods under the state's Medicaid program to sell, lease, lend or otherwise exchange rights, privileges or benefits to another person.

**101.15.013 Fraud Penalties**

(Rev. 11/01/08)

A person who violates the provisions of Section 43-7-70 of the S.C. Code of Laws is guilty of medical assistance fraud which is a Class A misdemeanor. Upon conviction, the person must be imprisoned not more than three (3) years or fined not more than $1,000 or both. Section 43-7-70 does not prohibit the prosecution of a person for conduct that constitutes a crime under another statute or at common law.

**101.15.02 Referral of Suspected Fraud Cases**

(Rev. 10/01/10)

Cases of suspected fraud will be investigated by SC DHHS in coordination with the Attorney General's Office. An Eligibility Worker who suspects that fraud has been committed must discuss the case with his/her supervisor and refer the case for investigation by forwarding a fraud summary to:

South Carolina Department of Health and Human Services

Division of Program Integrity

Post Office Box 8206

1801 Main Street

Columbia, South Carolina 29202-8206

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**101.15.03 Fraud Summary**

(Rev. 10/01/10)

The fraud summary must include the following information:

* Identifying Information
	+ Name and address of beneficiary;
	+ Type of benefits received or requested;
	+ County, case number and Medicaid number; and
	+ Name of worker making the report.
* Summary of the Situation
	+ Date of certification;
	+ Date of review prior to date that alleged fraud was discovered;
	+ A brief statement concerning the beneficiary's circumstances as reported at the last review;
	+ The date alleged fraud was discovered and a statement of the facts supporting the fraud allegation; and
	+ The period of ineligibility.
* Verification

Give the facts that verify the correct information concerning the eligibility factor involved. Such facts include:

* + Names and location of records used;
	+ Names and addresses of persons providing information;
	+ Names of other sources used to substantiate the information; and
	+ A copy of the application form and last review form, when applicable.

The fraud summary must be signed by the Eligibility Worker’s supervisor, indicating that the supervisor has reviewed the case record and fraud summary and have determined that, to the best of his/her knowledge, it contains all of the relevant information. SC DHHS Division of Program Integrity will contact the Eligibility Worker should additional information about the facts of the case be required.

**101.16 Overpayments/Underpayments**

(Eff. 10/01/05)

An overpayment may occur because:

* The beneficiary was ineligible for a period during which he/she received Medicaid benefits; or
* Medicaid paid more for the cost of medical services than it should have.

The overpayment could have resulted from agency or beneficiary error. If the overpayment resulted from agency error, the beneficiary is not required to repay the funds. Therefore, no overpayment summary is required. The Eligibility Worker documents the case record with the fact of the agency error and the period of time covered by the overpayment. Examples of agency error are:

* Failure to take action on reported information
* Failure to follow up on an anticipated change in circumstances
* Failure to re-determine eligibility in a timely manner
* Failure to apply policy or procedures correctly

If the overpayment resulted from beneficiary error, an overpayment summary is required. Examples of beneficiary error are:

* Withholding information
* Providing incorrect information
* Unreported changes

The beneficiary may willfully withhold information that he/she knows will affect his eligibility. In this case, refer to MPPM [101.15](#MPPM_101_15) in this chapter regarding beneficiary fraud. On questionable cases, the SC DHHS Division of Program Integrity will determine if information was willfully withheld.

An underpayment may occur when a beneficiary's income was overstated, and Medicaid failed to pay its full share of medical expenses. All underpayments are to be corrected upon discovery. If the under333payment resulted from agency error, the error may be corrected retroactively. Underpayments that resulted from beneficiary error are corrected, but they are not corrected retroactively. Necessary adjustments are made effective with the next month a change can be made. Underpayments must be corrected within 12 months from the month of discovery.

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**101.16.01 Completing an Overpayment Summary**

(Rev. 07/01/16)

Once it has been determined that a beneficiary error has occurred resulting in a potential overpayment, the Eligibility Worker must take the following actions:

1. Verify an error occurred.

2. Complete the [DHHS Form 928](http://medsweb.scdhhs.gov/EligibilityForms/FM%20928.pdf), Notice of Overpayment, and obtain supervisor’s signature and forward to the beneficiary informing him/her an overpayment referral has been made. The beneficiary will have 10 calendar days from the date on the SC DHHS Form 928, Notice of Overpayment, to contact the supervisor if he/she has questions or would like to discuss the referral.

3. Complete the [DHHS Form 3252](http://medsweb.scdhhs.gov/EligibilityForms/FM%203252%20ME.pdf), Overpayment of Medicaid Benefits, which must include the following:

* Beneficiary’s name, address and telephone number
* Medicaid ID Number and Social Security Number
* Period covered by the overpayment
* Summary of the facts pertaining to the overpayment including any background information on how the overpayment came to our attention (e.g., the client did not report the overpayment, SC DHHS discovered the overpayment later, etc.)

4. After 10 calendar days, submit the completed DHHS Form 3252 and DHHS Form 928 to the Division of Policy and Planning via a Service Manager ticket. In Service Manager, enter the following information:

 **Group:** Medicaid Eligibility

 **Category:** Medicaid Policy

 **Category Option:** Overpayment Summary

 **Subject line:** Overpayment of Medicaid Benefits.

Attach the completed DHHS Form 3252 and DHHS Form 928 to your ticket and submit. After reviewing the overpayment, the Division of Policy and Planning will forward the ticket to Program Integrity.

**101.16.02 Repayment of Medicaid Benefits Resulting from an Overpayment**

(Eff. 10/01/05)

The Division of Program Integrity will determine if the beneficiary owes a refund resulting from an overpayment. The amount owed depends upon whether the beneficiary used his Medicaid card. If it is determined that the beneficiary owes a refund for the error, the beneficiary will receive a letter from the Division of Program Integrity which will include his rights to file an appeal.

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**101.16.03 Repayment of Medicaid Benefits Resulting from Continued Benefits During an Appeal**

(Eff. 10/01/05)

If a beneficiary files an appeal and requests continued benefits pending the outcome of an appeal hearing, the [DHHS Form 3260](http://medsweb.scdhhs.gov/EligibilityForms/FM%203260%20ME.pdf), Request for a Fair Hearing, or written notice to receive continued benefits must be in the case record. If the decision upholds the action taken on the case, any Medicaid payments received during this period are subject to repayment. (Refer to MPPM [101.12.10A](#MPPM_101_12_10A).)

The Medicaid supervisor must complete the [DHHS Form 3252](http://medsweb.scdhhs.gov/EligibilityForms/FM%203252%20ME.pdf), Overpayment of Medicaid Benefits - Notice to Department of Receivables, to notify the Division of Program Integrity.

The Division of Program Integrity will determine the amount owed and bill the beneficiary. The amount owed depends upon whether the beneficiary used his Medicaid card during the continued benefits period. If it is determined that the beneficiary owes a refund, the beneficiary will receive a letter from the Division of Program Integrity, which will include his rights to file an appeal.

**101.17 Healthy Connections (Medicaid) Insurance Card**

(Eff. 03/01/08)

Medicaid eligible beneficiaries receive a plastic South Carolina Healthy Connections (Medicaid) Insurance Card. The front of the card includes the member’s name, date of birth, and Medicaid health insurance number. The back of the card includes:

* A number that providers may call for prior authorization of services outside the normal practice pattern or outside a 25-mile radius of South Carolina
* A toll-free number that may be utilized by providers to access the Medicaid IVRS. (Refer to MPPM [101.12.04](#MPPM_101_12_04) for information on IVRS.)
* A magnetic strip that may be utilized by providers in POS devices. (Refer to MPPM [101.12.04](#MPPM_101_12_04) for information on POS services.)

Refer to MPPM Chapter 104, Appendix X, for a copy of the Healthy Connections (Medicaid) Insurance Card.

**101.17.01 Instructions on the Use of the Medicaid Insurance Card**

(Eff. 03/01/08)

Beneficiaries must be informed of the proper use of the Healthy Connections (Medicaid) Insurance Card. This is accomplished via the card carrier. The explanation must ensure that the beneficiary understands the following:

* Possession of the card does not guarantee Medicaid coverage.
* The card is permanent and will not be replaced monthly.
* Only one person’s name appears on each card. If more than one family member is eligible for Medicaid, the family will receive a card for each eligible member.
* The card should be in the beneficiary’s possession at all times.
* The card should be shown to the provider of service(s) at the time of treatment.
* The card is not transferable. Only the person whose name is listed on the card is eligible. Use by other persons is illegal.
* The card may be used to obtain only those services/supplies/equipment covered by Medicaid.
* Inappropriate use of the card may result in the beneficiary being restricted to specified providers.
* The card may be used for emergency services out-of-state (outside a 25-mile radius of South Carolina). Emergency services must be reported to and authorized by the State Department of Health and Human Services program representatives. The out-of-state provider must call or write its program representative within 30 calendar days from the date of service/discharge for approval. Physicians must call (803) 898-2660. Hospitals must call (803) 898-2665.

**101.17.02 Procedures for Handling Returned Medicaid Insurance Card and Returned Mail**

(Eff. 03/01/08)

**Procedure for Handling Returned Medicaid Cards:**

Healthy Connections (Medicaid) Insurance Cards that are undeliverable by the United States Post Office are returned to the Eligibility Worker for disposition. To ensure the safety and security of the returned Medicaid cards, the following controls should be implemented:

* Returned cards are stored in a secure location.
* Proper disposition is made for each card within 30 calendar days.

Cases must be researched for a correct address. Those cards for which no address can be located must be kept in the secure location, and notification of case closure must be made. If a correct address is obtained, the card may be released to the beneficiary.

**Procedure for Handling Returned Mail:**

If mail is returned to the Local, Central Eligibility or Central Institutional unit processing office with a forwarding address, the Eligibility Worker must update HMS04 (Primary Individual Screen) in MEDS with the correct mailing address. The Eligibility Worker will use the new mailing address to forward the letter to the applicant/beneficiary.

If mail is returned because of an insufficient address, the Eligibility Worker must research MEDS for a correct address.

Those letters, for which a correct address cannot be located, must be kept in the case record. The Eligibility Worker must document in the case record that mail was returned and a forwarding address could not be located.

**101.17.03 Requesting a Replacement Medicaid Insurance Card**

(Eff. 03/01/08)

When a beneficiary requests a replacement Healthy Connections (Medicaid) Insurance Card, the Eligibility Worker must take the following steps:

1. Ensure that the beneficiary’s mailing address in the Medicaid computer system is correct.
2. If the beneficiary is an SSI recipient, instruct him/her to notify the county Social Security Administration office of the correct mailing address. (Note:This is very important because the mailing address cannot be corrected permanently until the Social Security Administration corrects the State Data Exchange file.)

If the beneficiary has called 1-800-772-1213 to report the address change, it will not correctly change the address to affect the Medicaid card. The beneficiary should be instructed to contact the area SSA office.

3. Check the secure location where returned cards are kept to see if the card is there. If so, give or mail the card to the beneficiary. If the card is not found, key the necessary information into the computer system to request a replacement card.

For Cúram, refer to the [Request a Medicaid Replacement Card](https://schhs.sharepoint.com/%3Ab%3A/r/sites/EES/Training/Curam/HCR/Job-Aids/Case%20Management/Request%20a%20Medicaid%20Replacement%20Card.pdf?csf=1&web=1&e=ZPnRKu) job aid at [Training Materials Portal-MAGI](https://www1.scdhhs.gov/ees/trainingportal/).

**101.18 Voter Registration**

(Eff. 03/01/14)

Congress enacted the National Voter Registration Act of 1993 (NVRA), requiring states to establish procedures to assist public assistance applicants and beneficiaries with registering to vote. Pursuant to the NVRA, all SC DHHS staff – including third party’s employees providing contract services to SC DHHS – must offer the following Voter Registration Services (VRS) to all applicants and beneficiaries:

* Distribution of Voter Registration Cover Letter;
* Distribution of Voter Registration Application (VRA);
* Distribution of Voter Registration Declination (VRD);
* Assistance selecting the appropriate form to complete, if requested;
* Assistance completing the appropriate form, if requested; and
* Acceptance and transmittal of completed VRAs to the appropriate County Board of Voter Registration, if returned to SC DHHS.

NOTE: The Voter Registration Cover Letter, VRA, and VRD collectively comprise the Voter Registration Packet. Each SC DHHS site shall keep an adequate supply of Voter Registration Packets available. Individual forms may be downloaded from [SC DHHS Medicaid Eligibility Forms](http://medsweb.scdhhs.gov/formslisting.htm).

SC DHHS will provide local eligibility offices with signs alerting visitors of the voter registration services. Local eligibility offices will be responsible for maintaining these signs.

**101.18.01 Voter Registration Services**

(Rev. 01/01/23)

VRS shall be offered (i) in person, (ii) electronically, and (iii) via telephone, fax, or mail, whenever an applicant/ beneficiary:

1. Applies for services;
2. Renews a service (i.e. at annual review); or
3. Submits a change of address.

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| **Procedures for Providing Voter Registration Packets** |
| **Face-to-Face:**When an applicant/ beneficiary visits a local eligibility office, the person designated by that office will offer the individual a copy of the Voter Registration Packet. The worker should document in MEDS/OnBase that the form was offered.NOTE: This service may be provided by a receptionist or an eligibility worker. At least one person must be present during all business hours to provide assistance. **By Telephone, Mail, Fax, or E-mail:**At Time of Application Request: When an individual requests a Healthy Connections Medicaid Application, the worker sending the application will also provide the Voter Registration Packet. The worker should document in MEDS/OnBase that the form was sent out.After an Application or Completed Review Form is Received by an Eligibility Worker for Processing: When additional information is needed to make an eligibility determination, the worker sending DHHS Form 1233 will also include the Voter Registration Packet. “Voter Registration Form” is to be checked on the DHHS Form 1233.  |

When VRS are offered, the Eligibility Worker should proceed as follows:

**Step 1: Inform the individual of Voter Registration Services.** This may be completed by offering a verbal explanation and/or providing a Voter Registration Packet.

**Step 2: Determine if the individual would like to receive Voter Registration Services**. The individual will be given the option whether or not to participate in VRS. If the individual accepts services, continue to Step 3. If the individual declines services, request the individual complete a VRD to verify he was offered the service.

**Step 3: Determine if the individual is registered to vote at his current address**. If the individual is registered at his current address, VRS are not needed; request that the individual complete a VRD to verify he was offered the services. If the individual has (i) never registered to vote in SC or (ii) changed his legal address since he registered to vote, provide a Voter Registration Packet and continue to Step 4.

**Step 4: Determine if the individual needs assistance completing the Voter Registration Packet**. Eligibility Workers may explain forms contained in the Voter Registration Packet, answer questions related to voter registration, and offer assistance reading and filling out the form. If the Eligibility Worker assists the individual, he must copy and attach any documents offered by the individual to his VRA (such as a current photo ID or copy of a current utility bill, bank statement, paycheck or other government document showing name and address).

**Step 5: Submitting and processing forms.** Different procedures will be followed depending on whether the individual elects to complete the VRA or VRD.

Individuals may return a completed VRA to either (i) their County Election Commission office; (ii) the Department of Motor Vehicles (DMV); or (iii) to SC DHHS. If an individual returns a completed VRA to SC DHHS, that SC DHHS site shall mail all completed VRAs to the appropriate [Board of Voter Registration](http://scvotes.org/how_to_register_absentee_voting) within two business days of receipt. Voter Registration Applications are NOT to be scanned into OnBase or kept with the client case file in any way.

Individuals should return a completed VRD to SC DHHS. The VRD shall be stored separately from the individual’s case file for at least twelve (12) months. VRDs will be entered into OnBase strictly to allow SC DHHS to track how many forms have been received. VRDs are to be scanned into OnBase as document type VRD, Keyword “Current Year”; e.g., “2023”. VRDs will not be associated with a Medicaid ID #.

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| --- |
| **Procedure for Entering Voter Registration** |
| Scanners and eligibility specialists should follow the below procedures if any voter registration documents are submitted with an application. **Scanners** If a voter registration is submitted with a paper application, add an electronic sticky note to the Cúram application in OnBase. For example, “VRD received with application” or “VRA received with application.” There is no need to complete the form on the OnBase Tracking Form.**Eligibility Workers** When working new applications, workers should complete the following tasks:1. Look for any sticky notes and/or indicator on the application in OnBase to see if there is documentation of Voter Registrations materials.
2. If there is nothing indicating Voter Registration forms have been sent or received, unless the applicant has specifically indicated on the application they do not want assistance or have submitted a declination form with the application, send the Voter Registration packet with DHHS Form 1233 as part of the request for additional information.

*Note: It is recognized that an applicant might receive/send more than one copy of the VR packet. However, to be compliant with federal regulations, we must have assurance that the person is given every opportunity to receive assistance to register to vote.*1. Update the OnBase Tracking Form with the appropriate response. If the eligibility specialist is providing the whole packet and has not had direct contact with the applicant, the appropriate response is: “C = Services Offered –Registration by Mail Form Given.”

Regardless of an applicant or beneficiary’s previous responses to this service, Voter Registration services must be offered at the time of application, at the time of review, and when the applicant notifies the agency of a change of address. If the Voter Registration form status changes from an initial entry, it does not need to be updated on the OnBase Tracking Form or in MEDS. The original entry is sufficient.Document action using both the MEDS and OnBase procedures below to allow for transition from MEDS to Cúram.**Cúram Procedure (all actions):** The eligibility specialist will be prompted during the application script to record a response to the question: “If you are not registered to vote where you live now, would you like to apply to register to vote here today?” If the options of “Yes” or “Response not included with the paper application” the system will send a Voter Registration packet to the applicant.**MEDS Procedure (all actions):**The valid values for “Voter Registration” can be accessed on HMS06 (Household Member Detail Screen) by pressing shift F1 on the <REASON> field.When the applicant/beneficiary accepts the application to register to vote or when the voter registration packet is mailed out, enter code “Y” under reason code F13.When the applicant/beneficiary rejects the application to register to vote, enter code “N”.Enter a reason code regardless of whether initial answer is “Y” or “N”. Valid reason codes are as follows:A = APPLICANT/RECIPIENT REGISTERED BY WORKER.B = APPLICANT/RECIPIENT ALREADY REGISTERED.C = SERVICES OFFERED - REGISTRATION BY MAIL FORM GIVEN.D = APPLICANT/RECIPIENT DECLINED OFFER TO REGISTER.E = APPLICANT/RECIPIENT NOT ELIGIBLE TO REGISTER TO VOTE.F = APPLICANT/RECIPIENT REFUSED TO SIGN DECLINATION FORM.NOTE: Code “G”, “No face-to-face contact with applicant/recipient,” previously entered for any applications received by mail, will no longer be used in any scenarios.**OnBase Procedure (all actions):**For All Voter Registration Services:Document action using the OnBase Tracking Form, MEDS-VRD, located under the SCDHHS-Misc document group.* + Select the SCDHHS-Misc group to retrieve only VRD documents.
	+ Select the SCDHHS-Medicaid group to retrieve all other MEDS documents.

On Tracking Form, select “Voter Registration” from the drop-down menu and indicate one of the following:A = APPLICANT/RECIPIENT REGISTERED BY WORKER.B = APPLICANT/RECIPIENT ALREADY REGISTERED.C = SERVICES OFFERED - REGISTRATION BY MAIL FORM GIVEN.D = APPLICANT/RECIPIENT DECLINED OFFER TO REGISTER.E = APPLICANT/RECIPIENT NOT ELIGIBLE TO REGISTER TO VOTE.F = APPLICANT/RECIPIENT REFUSED TO SIGN DECLINATION FORM.**For Voter Registration Declination Forms Only*** Only VRDs will be scanned into OnBase.
* VRDs are to be scanned into OnBase as document type “VRD”, Keyword “Current Year”; e.g. “2023”.
* VRDs will not be associated with a Medicaid ID #.
 |

**101.18.02 Political Neutrality and Confidentiality**

(Eff. 03/01/14)

In providing these services, SC DHHS will adhere to standards of political-neutrality and strict confidentiality.

To maintain a standard of political neutrality, SC DHHS employees shall not:

* Display any personal political preference or party allegiance;
* Seek to influence an applicant/beneficiary’s political preference or party registration through any statement or action;
* Seek to discourage an applicant/beneficiary from registering to vote through any statement or action;
* Intentionally convey to an applicant/ beneficiary, through words or actions, that a decision to use or not use VRS will have any bearing on the availability of Medicaid services or benefits;
* Intentionally convey to an applicant/ beneficiary, through words or actions, that a decision to register or to not register to vote will have any bearing on the availability of Medicaid services or benefits;
* Hold completed VRA forms for more than two business days from the date received.

To maintain a standard of strict confidentiality, SC DHHS employees are reminded that the following is considered confidential:

* Information contained in the completed VRA or VRD, including social security number, date of birth, etc.;
* Information regarding the physical location where an applicant applies to register to vote; and
* Driver’s License or State ID Number.

NOTE: This list is not comprehensive. If a SC DHHS employee at any time has questions regarding what constitutes confidential information, he should contact his supervisor for guidance.

For questions regarding SC DHHS NVRA policy contact:

SC DHHS NVRA Compliance

P.O. Box 8206

Columbia, SC 29202

Email: nvra-compliance@scdhhs.gov

**101.19 Medicaid Eligibility Quality Assurance (MEQA)**

(Rev. 03/01/13)

SC DHHS has contracted with the Center for Health Services & Policy Research (CHSPR) at the University of South Carolina (USC) to conduct eligibility monitoring reviews that will identify and/or develop:

1. Error trends
2. The need for policy clarifications
3. The need for additional training
4. Employee performance standards

USC submits written requests for files to be reviewed. SC DHHS must take the following steps within 15 calendar days of receiving the request:

1. Locate the requested file
2. Complete [DHHS Form 1259](http://medsweb.scdhhs.gov/EligibilityForms/FM%201259.pdf), Quality Assurance Case Review Checklist, and attach it to the front of the file
3. Ensure that the most current action and the action for the date to be reviewed are included in the file
4. Attach a copy of the email if the file is sent in response to a specific request from a reviewer
5. Attach a copy of the original request if file was not located and sent timely
6. Indicate if the file is sent to MEQA, PERM, or EQUIP

**101.19.01 Quality Measurements**

(Eff. 03/01/13)

The quality measurements used by USC to conduct SC DHHS eligibility reviews are:

1. Eligibility Quality Improvement Process (EQUIP)
2. Medicaid Eligibility Quality Assurance (MEQA)
3. Payment Error Rate Measurement (PERM)
4. Medicaid and Children’s Health Insurance Program Review Pilots
5. Special Project Reviews

**101.19.01A Eligibility Quality Improvement Process (EQUIP)**

(Eff. 03/01/13)

EQUIP is an internal eligibility review process that is used by the agency without contact with the beneficiary. EQUIP is limited to errors that were identified in PERM/MEQA reviews, and includes Alerts that report eligibility issues not included in the scope of the review. The primary objectives of EQUIP are:

1. Identify and address error trends
2. Develop employee performance standards

**101.19.01B Medicaid Eligibility Quality Assurance (MEQA)**

(Eff.01/01/13)

Medicaid Eligibility Quality Assurance (MEQA) is a federally mandated study. The primary objectives of MEQA are:

1. To measure, identify, and eliminate or reduce dollar losses as a result of erroneous eligibility determinations
2. To ensure that clients receive all of the benefits to which they are entitled

Note: Medicaid and Children’s Health Insurance Program Eligibility Review Pilots (MPPM 101.19.01D) will be substituted for MEQA Reviews until June 30, 2016.

**101.19.01C Payment Error Rate Measurement (PERM)**

(Eff. 01/01/14)

Payment Error Rate Measurement (PERM) is a federally mandated study. The primary objectives of PERM are:

1. To review fee for service, managed care, and Medicaid and SCHIP eligibility
2. To provide results of the reviews to be used to produce a national error rate

Note: Medicaid and Children’s Health Insurance Program Eligibility ReviewPilots (MPPM 101.19.01D will be substituted for MEQA Reviews until June 30, 2016.

**101.19.01D Medicaid and Children’s Health Insurance Program Eligibility Review Pilots**

(Eff. 01/01/14)

The Medicaid and Children’s Health Insurance Program Eligibility Review Pilots are federally mandated studies. The goal is to evaluate the transition to policy mandated by the implementation of the Affordable Care Act (ACA). Four streamlined review pilots will be conducted in lieu of Medicaid Eligibility Quality Assurance (MEQA) and Payment Error Rate Measurement (PERM) reviews. The primary objectives are:

1. To evaluate automated processes.

2. To evaluate caseworker actions.

**101.19.01E Special Project Reviews**

(Eff. 03/01/13)

The Center for Health Services & Policy Research (CHSPR) at the University of South Carolina (USC) also periodically conducts special project reviews as requested by the SC DHHS Management Team. Eligibility staff must cooperate with these reviews to the same degree as federally mandated quality reviews.

**101.19.02 Report of Eligibility Findings for EQUIP**

(Eff. 03/01/13)

EQUIP findings include any procedural and/or eligibility errors, and Alerts that identify eligibility information that falls outside of the scope of the review. Alerts provide changes and/or information that were discovered during the review but not considered by the Eligibility Worker who completed the determination. Alerts may or may not be the result of worker error.

Upon the completion of each case review, the USC reviewer will publish the EQUIP review findings in the Eligibility Quality Management Site in SharePoint.

**101.19.02A USC will report EQUIP findings in the following ways**

(Eff. 03/01/13)

1. Correct
2. Incorrect
	1. Eligibility Errors – Medicaid eligibility was incorrectly determined for a single member, or all members of a budget group
	2. Procedural Errors – Medicaid eligibility was correctly determined but policy and/or procedures have been overlooked or misinterpreted. A procedural error may or may not result in an eligibility error.
3. Unable to locate
4. Dropped

**101.19.02B SC DHHS Response to EQUIP Findings**

(Eff. 03/01/13)

The Quality Manager will retrieve EQUIP findings from SharePoint, and submit a report of error and Alert findings for each supervisory unit to the following:

1. The Eligibility supervisor
2. The appropriate Regional Administrator
3. The appropriate Division Director
4. The appropriate Regional Trainer
5. The Director of Eligibility Training
6. The Director of Eligibility Policy
7. The Performance Manager

Within five (5) business days of receiving the EQUIP findings, the supervisor must schedule a conference with the appropriate worker to review all error findings. The worker must complete the following action(s) within ten (10) calendar days of receiving the EQUIP error and/or Alert findings:

1. Correct all eligibility errors
	1. The supervisor and Eligibility Worker must schedule a conference with the Quality Manager to discuss the finding and corrective action(s)
2. Correct all procedural errors
	1. If necessary, the supervisor and/or eligibility worker may contact the Quality Manager to ask questions or obtain clarifications regarding the findings
3. Initiate or complete required actions needed to address any reported finding that was not considered in the eligibility determination.

Within fifteen (15) calendar days of receiving an error finding, the supervisor must:

1. Review the case to ensure the required corrective action(s) are completed, and verification regarding any new findings is requested and/or acted upon, if required. Following the review, submit DHHS Form 947, Response to Preliminary QA Findings via Service Manager ticket to the Eligibility, Enrollment and Member Services designee. The response must explain:
	1. The corrective action(s) initiated or completed, and/ or
	2. A rebuttal of the Preliminary Findings, including a detailed rationale and documentary evidence to support the disagreement
2. The Eligibility, Enrollment and Member Services designee will distribute the DHHS Form 947, Response to Preliminary QA Findings to:
3. The eligibility supervisor
4. The appropriate Regional Administrator
5. The appropriate Division Director
6. The appropriate Regional Trainer
7. The Director of Eligibility Training
8. The Director of Eligibility Policy
9. The Performance Manager
10. The Quality Manager
11. The Quality Manager must take the following action when the DHHS Form 947, Response to Preliminary QA Findings reports a disagreement with the review:
	1. Submit any supported disagreement to the USC MEQA Staff Manager for reconsideration
	2. Respond to any unsupported disagreement
12. Alert disputes are sent to the Quality Manager, who must take one of the following actions:
	1. Inform USC and the eligibility staff of supported findings, or
	2. Inform the eligibility staff of unsupported findings

**101.19.03 Report of Eligibility Findings for MEQA, PERM, and Medicaid and Children’s Health Insurance Program Review Pilots**

(Eff.01/01/14)

At the completion of each case review, the USC reviewer will submit DHHS Form 946, Preliminary QA Findings, including any procedural errors and eligibility errors.

The USC reviewer will submit a report of the MEQA or PERM findings to:

* 1. The Eligibility Worker who completed the action
	2. The supervisor of the eligibility worker who completed the action
	3. The supervisor of the current eligibility worker\*
	4. The Director of Eligibility Training
	5. The Director of Eligibility Policy
	6. The appropriate Regional Administrator
	7. The appropriate Division Director
	8. The appropriate Regional Trainer
	9. The Performance Manager
	10. The Quality Manager

\*The current Eligibility Worker is responsible for the completion of any corrective action(s).

**101.19.03A USC will report MEQA and PERM findings in the following ways**

(Eff. 03/01/13)

1. Eligible – Medicaid eligibility was correctly determined. Policy and/or procedures may have been overlooked or misinterpreted but did not result in an eligibility error.
2. Ineligible – Medicaid eligibility was incorrectly determined for all members of a budget group
3. Ineligible budget group member(s) – Medicaid eligibility was incorrectly determined for one or more members of a budget group.
4. Eligible – Liability overstated (when an institutionalized individual’s recurring liability is determined to be more than it should be)
5. Eligible – Liability understated (when an institutionalized individual’s recurring liability is determined to be less than it should be)

**101.19.03B SC DHHS Response to MEQA and PERM Error Findings**

(Eff. 03/01/13)

Within five (5) business days of receipt, the supervisor must schedule a conference with the Eligibility Worker to review the case findings. The following issues must be discussed and documented:

1. Policy relative to the eligibility finding
2. Actions that must be taken to correct any procedural and/or eligibility error(s) identified, or
3. The decision to rebut the findings, if applicable, including policy and supporting documentation that supports the disagreement

Upon completion of this discussion, a response to the findings is provided on the [DHHS Form 947](http://medsweb.scdhhs.gov/EligibilityForms/FM%20947.pdf), Response to Preliminary QA Findings, which supports:

1. Agreement With the Review Findings
2. Within ten (10) calendar days of the conference, the Eligibility Worker must take the required actions to correct the case.
3. Within fifteen (15) calendar days of receiving the error finding, the supervisor must:
	1. Review the case to ensure the required corrective action(s) are completed and/or initiated, and verification regarding any new findings is requested and/or acted upon.
	2. Submit DHHS Form 947 via Service Manager ticket that explains the corrective action(s) discussed in the conference and completed by the Eligibility Worker.
4. Rebuttal of the Review Findings
5. Within ten (10) calendar days of the conference, the supervisor must report the decision to rebut the error finding via Service Manager ticket.
6. The rebuttal must include policy and supporting documentation that supports the disagreement.
7. If the rebuttal is not supported following review, the Quality Manger will schedule a conference within ten (10) calendar days with:
	1. The eligibility worker;
	2. The eligibility supervisor; and
	3. The Regional Trainer.
8. If the rebuttal is supported following review, the Quality Manager will submit the rebuttal to USC MEQA/PERM and schedule a conference within ten (10) calendar days with:
	1. The eligibility supervisor;
	2. The Regional Trainer; and
	3. A representative from USC MEQA/PERM.
9. If an agreement is reached between all parties during the conference that supports the review findings, the Eligibility Worker must follow the procedures for Agreement with the Review Findings to complete the corrective action(s).
10. If an agreement is not reached between all parties during the conference, the Quality Manager will schedule a conference with the following:
	1. The eligibility supervisor
	2. A representative from USC MEQA/PERM
	3. The Director of Eligibility Training, or designee
	4. The Director of Eligibility Policy, or designee

When an agreement is reached between all parties during this conference that supports the review finding, the Eligibility Worker must follow the procedures for Agreement With the Review Findings to complete the corrective action(s).

When an agreement is reached between all parties during this conference that overturns the review finding, USC must issue a revised finding within ten (10) calendar days.

**101.19.03C Corrective Action Plan for MEQA and PERM Quality Management**

(Eff. 08/01/19)

The Eligibility, Enrollment and Member Services will maintain a log to track activities related to the Quality Assurance Findings. At the conclusion of the review process, the following actions are required:

1. The Eligibility, Enrollment and Member Services will provide the completed tracking document within sixty (60) calendar days to:
	1. The Director of Eligibility Policy;
	2. The Director of Eligibility Training;
	3. The Regional Administrators;
	4. The Division Directors;
	5. The Performance Manager; and
	6. The Quality Manager.
2. USC will provide a final report within sixty (60) calendar days to:
	1. The Director of Eligibility Policy;
	2. The Director of Eligibility Training;
	3. The Regional Administrators;
	4. The Division Directors;
	5. The Performance Manager;
	6. The Quality Manager; and
	7. The Program Director.
3. Within thirty (30) calendar days of receiving the USC Final Report, a Corrective Action Plan (CAP) must be developed to address the trends that were identified from the tracking document and the USC Final Report. The CAP must address, but is not limited to the following:
4. Additional training (should contain specific information regarding who will conduct the training, length of the training, who will attend, and the topic of the training);
5. Special monitoring efforts by the supervisor (should contain specific information regarding the length of the monitoring effort, the method used to conduct the effort, and issue(s) being monitored); and
6. Staff meetings to go over policy clarifications that were provided in the form of manual clarifications or Medical Support Mailbox answers.
7. The Corrective Action Plan will be sent to:
	1. The Eligibility, Enrollment and Member Services Director;
	2. The Division of Eligibility Training Director;
	3. The Division Directors;
	4. The appropriate Regional Administrator;
	5. The Performance Manager; and
	6. The Quality Manager.

**101.19.04 Beneficiary Error**

(Eff. 03/01/13)

If an eligibility error is the result of an action by the beneficiary and results in an overpayment of benefits, within five (5) business days of discovery of the error, [SC DHHS Form 928](http://medsweb.scdhhs.gov/EligibilityForms/FM%20928.pdf), Notice of Overpayment Referral, must be sent to the beneficiary. At the end of ten (10) calendar days, a copy of SC DHHS Form 928, [SC DHHS Form 3252](http://medsweb.scdhhs.gov/EligibilityForms/FM%203252%20ME.pdf), Overpayment of Medicaid Benefits, and [SC DHHS Form 947](http://medsweb.scdhhs.gov/EligibilityForms/FM%20947.pdf), Response to Preliminary QA Findings, must be submitted to the Eligibility, Enrollment and Member Services. Upon review, the Eligibility, Enrollment and Member Services will take one of the following actions:

1. Determine that the overpayment is supported
	1. Forward the overpayment summary to the Division of Program Integrity
	2. Inform the supervisor
	3. Inform the Quality Manager
2. Determine that the overpayment is unsupported and inform the following of the reason
	1. The supervisor
	2. The eligibility worker
	3. The Quality Manager

**101.19.05 Beneficiary Cooperation**

(Eff. 03/01/13)

All Medicaid beneficiaries are required to cooperate with USC/MEQA/PERM during their review process. When a beneficiary fails to cooperate, USC/MEQA/PERM will notify the supervisor and Eligibility Worker.

Upon receipt of [SC DHHS Form 946](http://medsweb.scdhhs.gov/EligibilityForms/FM%20946.pdf), USC Preliminary Error Findings, indicating beneficiary non-cooperation, the eligibility worker must send [SC DHHS Form 1234](http://medsweb.scdhhs.gov/EligibilityForms/FM%201234.pdf), Medicaid Quality Assurance Review Checklist, to request contact and/or information from the beneficiary.

1. For SSI-related categories
	1. Initiate a full review of the beneficiary’s eligibility, requesting the information that was not provided within ten (10) calendar days
	2. If the beneficiary provides all of the requested information, it must be forwarded to USC/MEQA/PERM within five (5) business days.
	3. If the requested information is not provided to complete the review, close the case for failure to provide requested information.
		1. For beneficiaries residing in a nursing home, work closely with the facility to avoid closure, if possible.
2. For FI-related categories
	1. If the beneficiary is an eligible adult in Low Income Families, initiate an annual review, requesting the information that was not provided within ten (10) calendar days
	2. If the requested information is not provided to complete the review, the Eligibility Worker must initiate closure for the adult members of the budget group for failure to provide requested information.
		1. The eligibility of children is protected and must not be terminated for one year from the date of the decision unless it is determined that eligibility was approved inaccurately.
		2. The children remain eligible in the LIF/PCR budget group until the next review date.
	3. If information is returned that would affect the child’s current eligibility, but there is no evidence that eligibility was approved inaccurately, file the information in the case record. Act on the information at the next annual review to determine if it is still valid.
	4. The eligibility of a pregnant woman is protected until the end of the post-partum period and cannot be terminated unless it is determined that eligibility was approved inaccurately. File the information in the case record.

**101.20 Telecommuter Supplemental Policy – Eligibility Application Processing at Home**

(Eff. 08/01/14)

The South Carolina Department of Health and Human Services (SCDHHS) eligibility workers and supervisors may submit a request to work from home in order to process eligibility applications outside normal working hours (8:30 a.m. – 5:00 p.m.) including evenings and weekends. Any worker or supervisor interested in participating must submit a written request to his/her supervisor for consideration. This is a time limited opportunity to address the high number of pending applications. This option can be used by staff eligible to work overtime, as well as staff who is participating in dual employment with SCDHHS for the purpose of assisting with eligibility determinations.

A Telecommuter Agreement must be signed by the employee, the supervisor and the Program Director for Eligibility, Enrollment and Member Services.

All existing SCDHHS Telecommuter, HIPAA, IT and overall agency policies are to be followed by eligibility employees wishing to process eligibility applications outside of their normal scheduled working hours. In addition, the following supplemental policies must be followed:

**Orientation and Terms**

All employees requesting approval to telecommute, as well as their supervisors must participate in an orientation session regarding telecommuting.

Telecommuting for Eligibility employees is strictly for processing Medicaid applications. The employee must work a full schedule during the day (at least 37.5 hours per week) to qualify for telecommuting outside typical working hours. Designated days and hours for working at home must be approved by the supervisor in advance. The supervisor and regional performance manager are responsible for monitoring performance and insuring quality performance and productivity are maintained. The ability to telecommute can be revoked at any time.

**Network Access:**

For personal computers and agency issued laptops, telecommuters must obtain VDI software in order to access DHHS eligibility programs, including MEDS and OnBase. (VDI software must be requested through Service Manager.)

Agency-owned equipment is for agency use only. VDI may be run on a personal computer. However, no entity within SCDHHS will make any attempt to troubleshoot or support a non-agency owned machine. Telecommuter computers are subject to audit at will without prior notification

**HIPAA/Privacy Policy:**

Refer to SC DHHS Policy for HIPAA and privacy guidelines.

Reminders: Always lock (control+alt+delete) computer before stepping away from it when working offsite.

**Contacting Applicants, Beneficiaries and Third Parties:**

Personal telephones are not to be used for agency business. Any telephone or face-to-face interaction with applicants, beneficiaries, authorized representatives or third parties is to take place during normal business hours in an SC DHHS office/sponsored worker location.

**Application Processing and Printing Documents:**

Do not print any documents related to Medicaid or the Medicaid application when working offsite.

Do not carry printed documents related to application processing outside of onsite office.

Do not save any work related documents on your desktop.

For any forms that need to be printed and mailed to an applicant, beneficiary or third party:

* 1. All printing should take place in the office following an offsite work session.
	2. For printing needs identified during an offsite work session, keep a running list of what needs to be printed and mailed to continue processing an application.
	3. Print necessary forms and mail the very next working day from the office. Do not take printed documents home or to another location off site.

The worker is responsible for insuring that the offsite work environment is physically secure and that case related information is not accessible to any other individuals such as household members and guests.

The worker is responsible for having adequate Internet access to access systems necessary to conduct job functions identified for telecommuting purposes.

**101.21 Person Composite Service**

(Rev. 11/01/18)

The Person Composite Service (PCS) is a web-based portal used to validate and verify applicant information from multiple sources. The PCS must be used in Google Chrome. DO NOT use the Person Composite Service in Internet Explorer. The pages will not display correctly.

Sources and available information include:

* Social Security Administration (SSA)
	+ Social Security Number (SSN) Verification
	+ Citizenship Verification
	+ Quarters of Coverage Verification (Work Quarters)
* South Carolina Department of Employment and Workforce (SCDEW)
	+ Wage Payments
	+ Unemployment Compensation Payments
* Person Composite Service (PCS) Wage Income
	+ Employment History
	+ Annual Compensations
	+ Pay Periods (including employer, pay date, pay period end date, hours/week, gross income, net payment)
* SCDHHS Cúram and MEDS
	+ Eligibility History (Full Benefits Only at this time.)
* SSA Income
	+ SSN Verification
	+ Title II Monthly Income Verification (if Yes, then displays month, gross/net amounts and overpayment deduction)
	+ Payments Suspended
	+ Death Recorded
	+ Disability Confirmed by SSA
	+ Payments Ongoing

**NOTE:**

Until further notice, the “Check Address” is listed as an option but will not return any information.

The information is used to verify evidence on an Insurance Affordability Application Case (Application Case) or an Insurance Affordability Case (Integrated Case) such as Income, SSN Details and Citizenship. PCS is one tool that can be used to electronically verify information. If a member of the household has outstanding verifications, check electronic sources before requesting any documentation from an applicant or beneficiary.

A worker’s security role determines his or her ability to use the Person Composite Service and which systems may be accessed or queried. The worker can only access the types of information necessary to fulfill his/her assigned job functions.

The worker must follow the process described in the Job Aid: [Using the Person Composite Service](https://team.scdhhs.gov/OPS/EES/ACA%20%20Access%20Training/67_Using%20the%20Person%20Composite%20Services.pdf)for each person listed as an applicant on the case. **Use the Person Composite Service:**

1. After a paper application has been entered and submitted in Cúram (Only if no automated verification results are returned from the Federal Hub and/or SCDEW);
2. Before adding a new person to an Insurance Affordability case;
3. When completing a case review;
4. When there is a Change of Circumstance (COC);
5. When two cases are already approved and you need to obtain Eligibility History for the reconciliation process.

The applicant’s First Name, Last Name, Date of Birth and Social Security Number (SSN) are required to retrieve information from the PCS.

**When using the Person Composite Service:**

* ONLY Request information needed for an application to be processed.
* ONLY Request information for applicants on the application to be processed. (The worker must NOT search for information on an individual who is not part of an application he/she is processing.)
* Verification requests are tracked. If information is accessed inappropriately, the worker will incur a security violation per agency policy and may be subject to progressive disciplinary action.

Do not make multiple requests for SSA data. If SSN or Citizenship data has already been requested and verified using the Federal Hub or other verification sources, DO NOT request the information again via the Person Composite Service.

**101.22 Reserved for Future Use**

(Deleted 06/01/21)

**101.23 Non-Financial and Income Verification Matrix**

(Rev. 08/01/15)

The Non-Financial and Income Verification Matrix can be found at MPPM 105.01.01.

**101.24 Resource Verification Matrix**

(Rev. 08/01/15)

The Resource Verification Matrix can be found at MPPM 105.01.02.

**101.25 Long Term Care Verification Matrix**

(Rev. 08/01/15)

The Long Term Care Verification Matrix can be found at MPPM 105.01.03