

## ME Determine Eligibility

Determine Eligibility		
Item	Details	VA "As-Is" Details
<b>Description</b>	<p>The <b>Determine Eligibility</b> business process receives eligibility application data set from the receive inbound transaction process; checks for status (e.g., new, resubmission, duplicate); establishes type of eligible (e.g., children and parents, disabled, elderly, or other); screens for required fields; edits required fields; verifies applicant information with external entities; assigns an ID; establishes eligibility categories and hierarchy; associates with benefit packages, and produces notifications.</p> <p><b>NOTE:</b> A majority of States accept the designation of eligibility from other agencies (SSI, TANF, SCHIP, and other), in which case this business process will not be used by the Medicaid agency for those individuals. In these situations, Medicaid receives and stores the member information sent from other sources in the Member data store. This may require conversion of the data. However, this process will be used by the other States which require the TANF, disabled, elderly applicant to apply for Medicaid, and where the Medicaid agency determines eligibility for State-only programs.</p>	<b>2010 MITA:</b> No changes
<b>Trigger Event</b>	<ol style="list-style-type: none"> <li>1. Interaction-based Trigger Event:               <ol style="list-style-type: none"> <li>a. Original eligibility application data set</li> <li>b. Resubmitted eligibility application data set</li> <li>c. Eligibility application cancellation data set</li> </ol> </li> <li>2. User Specified Trigger Event (date): Time for Redetermination.               <ol style="list-style-type: none"> <li>a. Spend down calculation or data</li> <li>b. Calculate cost share</li> </ol> </li> </ol>	<b>2010 MITA:</b> No changes
<b>Result</b>	<ol style="list-style-type: none"> <li>1. Eligibility application status set to: accepted, denied, or pending for research/additional information.</li> <li>2. Eligibility is determined as approved, denied, pending for additional information or review, or cancelled.</li> <li>3. Member eligibility record completed and sent to <b>Manage Member Information</b> to process and load into Member data store.</li> <li>4. Member notification prepared and data set sent to the <b>Manage Applicant and Member Communication</b> process.</li> <li>5. Tracking information regarding the interchange as needed for the <b>Determine Eligibility</b> process, measuring performance and business activity monitoring.</li> <li>6. Feed into <b>Enroll Member</b> for Managed Care.</li> </ol>	<b>2010 MITA:</b> 1&2 - Virginia Medicaid does not "pend" eligibility applications. Currently, the applications are only input when all information is approved (approved status). *Note: Applications are not "pending" in Va MMIS.

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Business Process Steps	<ol style="list-style-type: none"> <li>1. Start: Receive eligibility application data set (cover all trigger events i.e., time events).</li> <li>2. Verify status of application (new, resubmit, duplicate, and redetermination).</li> <li>3. Validate syntax and semantic requirements associated with children and families eligibility application. Business rules identify fatal and non-fatal errors and associated error messages.</li> <li>4. Validate completeness and required fields. Business rules identify mandated fields and apply edits.</li> <li>5. Meet with applicant or member head of household as scheduled by the <b>Manage Applicant and Member Communication</b> process. Review member application and additional information provided by member in determination process, which entails completing the following steps as appropriate:               <ol style="list-style-type: none"> <li>a. Verify applicant name, date of birth, gender, Social Security Number, and other required demographic elements. Validate applicant information with sources, e.g., Vital Statistics file, and SSA.</li> <li>b. Verify income eligibility. Apply income standard (dollar amount) and methodology (rules for what is counted); verify applicant documentation (e.g., bank statements) with financial institutions.</li> <li>c. For spend down applicants, verify that qualifying medical care expenditures amount has been met.</li> <li>d. Verify resource eligibility. Apply resource standard (dollar amount) and methodology (rules for which assets are counted and how they count); verify applicant documentation.</li> <li>e. Verify immigrant status. Determine which immigrant classification the individual belongs to (if applicable); verify documentation.</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>3. DMAS doesn't understand why this only speaks of children &amp; family? Wouldn't the adult population also be included?</li> <li>5. Virginia has no mandatory face-to-face interview requirement.</li> </ol>

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Business Process Steps (Cont'd)	<p>f. Verify residency. Check documentation proving residency in the State (Note, if institutionalized in another State, eligibility stays with State of residency)</p> <p>g. Verify other coverage. Validate information supplied by applicant; verify with other coverage sources not referenced by applicant.</p> <p>6. For Applicants, verify the following:</p> <p>a. Determine transfer of resources. Determine if a transfer has occurred and compute the number of months before Medicaid benefits can begin based on the value of the transferred resources.</p> <p>b. Verify institutional vs. non-institutional status. Institutionalization or community care status calls for different eligibility rules.</p> <p>c. Determine if spousal impoverishment applies. If one spouse remains in the community and the other is institutionalized, the community spouse's resources and income may be disregarded.</p> <p>7. Determine eligibility for QMB, SLMB.</p> <p>8. For disabled applicants, verify disability. Determine that applicant meets disability qualifications.</p> <p>9. For pregnant women, verify pregnancy.</p> <p>10. Apply composite eligibility determination rules — summation of all rules determines if applicant is eligible or not, and if eligible, for which category of eligibility.</p> <p>11. Determine other eligibility categories — identify other eligibility categories for which applicant may be eligible, and determine hierarchy of applicability in the case of multiple eligibilities; this includes eligibility for other programs, e.g., Disability, Veterans Administration, and Indian Health Service.</p> <p>12. Assign I.D.</p> <p>13. Assign eligibility category (ies) [some children in family may not be eligible for Medicaid, e.g., too old to qualify for income level].</p> <p>14. Associate benefit packages [need State-specific rules on which eligible categories map to which benefit packages and services; do benefit packages include Manage Care? Which are optional?]</p> <p>15. Load eligibility information into Member data store</p> <p>16. End: Request that the <b>Manage Applicant and Member Communication</b> process generate notifications.</p>	<p>5. (A&amp;F) DMAS Accepts declarations unless they are questioned.</p> <p>6. Only applicable for LTC.</p> <p>7. This should also include Medicare Savings Programs.</p> <p>11. DMAS does use a hierarchy. DMAS refers applicants to other programs but does not determine eligibility. DMAS doesn't do VA, IHS or disability determinations.</p> <p>16. DMAS doesn't have a single source. The Medicaid, MCO, and FAMIS handbooks are on the Internet and available to the public. The MMIS benefit reports contain benefit package details.</p> <p>Medicaid and FAMIS references (handbooks under the "Client Services" section of the DMAS home page): <a href="http://www.dmas.virginia.gov/">http://www.dmas.virginia.gov/</a> Managed care references: <a href="http://www.dmas.virginia.gov/mc-home.htm">http://www.dmas.virginia.gov/mc-home.htm</a>, <a href="http://www.virginiamanagedcare.com/">http://www.virginiamanagedcare.com/</a></p> <p>13 &amp; 14. MMIS benefit package reports are generated on demand by DMAS. Reports available:</p> <ul style="list-style-type: none"> <li>• RS-O-080, Benefit Package Enrollment Rules Report. Shows by benefit package, all the associated enrollment rules, its effective dates, its related values, and the values effective dates.</li> <li>• RS-O-090, Aid Category Eligibility Rules Report. Listed by aid category (A/C) showing data for the A/C, the benefit plans related to the A/C, and eligibility rules and rule values by relationship code for the A/C.</li> </ul> <p>*Note: DMAS can also look at benefit package screens and benefit rules screens on the MMIS.</p> <p>*Note: The process stated in the framework is out of order for Va Medicaid.</p>

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<b>Shared Data</b>	<ol style="list-style-type: none"> <li>1. Member data store and custodial information; school, special schools tuition.</li> <li>2. Eligibility Categories and Hierarchy Table</li> <li>3. Benefit Plans and Associated Services Table</li> <li>4. TANF eligibility</li> <li>5. SSI eligibility</li> <li>6. SSP eligibility</li> <li>7. Spend down amount data store</li> <li>8. Veterans Administration</li> <li>9. Indian Health Service</li> <li>10. INS</li> <li>11. Other insurers and type of coverage</li> <li>12. Bank account balances</li> <li>13. Employer records</li> <li>14. Fraud case file</li> <li>15. Vital Statistics</li> <li>16. Aging or elderly services</li> </ol>	<p><b>2010 MITA:</b> DMAS receives this information but does not share it, except with SSI. PHI, such as from the cancer registry, is shared with other health care areas.</p>
<b>Predecessor</b>	<ol style="list-style-type: none"> <li>1. Receive inbound transaction process; receives paper and/or electronic applications, and generates application data sets.</li> <li>2. <b>Manage Applicant and Member Communication</b> process schedules the face to face, or phone interview, receives an application, or receives a referral; logs in request and prepares a package of eligibility information which is sent to the <b>Determine Eligibility Process</b>.</li> </ol>	<p><b>2010 MITA:</b> No changes</p>
<b>Successor</b>	<ol style="list-style-type: none"> <li>1. Notify applicant, member being redetermined or guardian.</li> <li>2. Update Member data store.</li> </ol>	<p><b>2010 MITA:</b> No changes</p>
<b>Constraints</b>	<p>A majority of Medicaid agencies accept the eligibility determination of the SSA for the SSI population. Many States delegate TANF eligibility to a sister agency. Some Medicaid agencies choose to perform the eligibility determination function themselves. States are responsible for non-SSI-linked eligibility. States differ in the rules applied to eligibility determination and the order in which the rules are applied. In all cases, determining disability status is time consuming.</p>	<p><b>2010 MITA:</b> DMAS doesn't automatically accept eligibility with TANF or SSI today.</p>

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Failures	<p>A member eligibility application may fail at the following steps:</p> <ol style="list-style-type: none"> <li>1. Duplicate or cancelled application.</li> <li>2. Applicant or member fails to keep scheduled appointment or provide additional information as requested.</li> <li>3. Required fields missing or not correct.</li> <li>4. Verification with internal or external sources.</li> </ol> <p><b>Note:</b> The <i>Determinate Eligibility</i> Process does not fail because the applicant is found ineligible, only because conditions are such that the process cannot be successfully completed.</p>	<p><b>2010 MITA:</b></p> <ol style="list-style-type: none"> <li>1. DMAS considers this withdrawn, not cancelled.</li> <li>2. Members are not required to keep appointments. DMAS doesn't require face-to-face appointments.</li> </ol>

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<p><b>Performance Measures</b></p>	<ol style="list-style-type: none"> <li>1. Time to complete eligibility determination process = ___ days</li> <li>2. Accuracy of decisions = ___%</li> <li>3. Consistency of decisions and disposition = ___%</li> <li>4. Error rate = ___% or less</li> </ol>	<p><b>2010 MITA:</b></p> <p>1. Applications, including requests for retroactive coverage, must be processed within 45 calendar days for all applicants other than pregnant women, women in the Breast and Cervical Cancer Prevention and Treatment Act group, or individuals needing a disability determination</p> <p>Applications for pregnant women must be processed within 10 working days of the agency's receipt of the signed application form.</p> <p>Breast and Cervical Cancer Prevention and Treatment Act women must be processed within 10 working days of the agency's receipt of the signed application form.</p> <p>For individuals who require a disability determination to meet the covered group requirements, the time standard for processing an application is 90 calendar days.</p> <p>The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:</p> <ul style="list-style-type: none"> <li>*the applicant's inability to furnish necessary information for a reason beyond his/her control</li> <li>*a delay in receipt of information from an examining physician (for disability determinations)</li> <li>*a delay in the disability determination process</li> <li>*a delay in receiving DMAS decision on property transfer undue hardship claim, or</li> <li>*an administrative or other emergency beyond the agency's control</li> </ul> <p><i>*Note: 2, 3, &amp; 4. DMAS is working on this.</i></p>