P-2423 Processing Eligibility Decisions (Continued)

I. Changes Related to Managed Care

1. A Person Leaves a Managed Health Care Plan Household

When an individual leaves a managed health care plan household, files an application, and is eligible for assistance for Medicaid or VHAP as a separate household, the individual retains membership in the managed health care plan. Set a new review period for the new household, even if the person is in the guaranteed period. The person will receive the remainder of the guaranteed period in the new household.

Examples: An ANFC-related household receives Medicaid benefits through a managed health care plan. One parent in the two-parent household leaves. The parent reports the change in address, files an application, is eligible for VHAP, and continues in the managed health care plan. Close the parent in the ANFC household and set the person up in a separate VHAP household.

An ANFC-UP household receives Medicaid benefits through a managed health care plan. The UP gets a job and leaves the household. He is not eligible for VHAP. Since he was in the guaranteed six-month period, however, his coverage continues if he reports the change in address. If he does, set him up as a separate household. His category code will be VHAP-Managed Care. If he does not report his change of address, close him because his whereabouts are unknown. The guaranteed period will end.

When an individual leaves a fee-for-service household and becomes a separate household, he or she remains in fee-for-service until the next scheduled opportunity to enroll in managed care.

2. Managed Care Coverage Changes to Fee-For-Service

Whenever a recipient changes from managed care coverage to fee-for-service, he or she must receive an adverse action notice. The last day of managed care coverage will always be the last day of the month. Adverse action notice is required

because fee-for-service has copayments and managed care coverage does not.

For example, you are notified on January 4 that an ANFC-related Medicaid recipient in a managed health care plan has acquired insurance (such as through employment) effective January 10. The Medicaid benefits delivery system must change to fee-for-service (M103). You enter the insurance in ACCESS on the INSU panel on January 8. ACCESS will derive a new category code, autoapprove the change, and generate a notice. The last day of coverage in a managed health care plan will be January 31.

P-2423 Processing Eligibility Decisions (Continued)

I. Changes Related to Managed Care

3. Reapplications After Being in a Managed Health Care Plan

An ANFC or ANFC-related Medicaid recipient will receive benefits through the fee-for-service system for the first month of coverage if:

- o the recipient had been in a managed health care plan at the time of closure and
- o the recipient reapplies and is found eligible after the fifth working day of the first month of closure (If eligibility is approved after adverse action deadline in the first month of closure, benefits will be delivered through the fee-for-service system for the first two months of coverage.)

Example: Sally began Medicaid participation in a managed health care plan in October. She is due for review in March and does not return her forms. Medicaid closes effective April 1. On April 5, she sends in her review forms. Her case is treated as an application. She is found financially eligible on April 12. Even though her eligibility is effective April 1 so she has no break in benefits, she is placed in the fee-for-service system because it is too late in the month to reinstate managed care. If slots are available in her plan, she will be enrolled beginning May 1. (If she had sent in her forms on March 25 and had eligibility approved on April 2, managed care coverage would have been reinstated for April 1.)

4. Household Changes

* A person who is in managed care remains in managed care even if he or she moves into a fee-for-service household. The fee-for-service household will be given an opportunity to enroll in managed care at the next scheduled opportunity.

* If a person receives benefits through fee-for-service and moves into a managed care household, he or she will move into that household's managed health care plan as soon as administratively possible (M103.24). This may be at the household's next review.

5. Guaranteed Period

* See M101 for an explanation of the one-time guaranteed six-month enrollment period. During this period a client may lose Medicaid eligibility but still continue managed care coverage. In this situation, the client receives the VHAP-Managed Care package for the remainder of the guaranteed period rather than the more complete Medicaid package.

P-2423 Processing Eligibility Decisions (Continued)

I. Changes Related to Managed Care (Continued)

5. Guaranteed Period (Continued)

Example: Paula and her daughter receive ANFC-related Medicaid. They are in a six-month guaranteed period from November through April. Paula gets a promotion at work effective January 1. She reports it on January 9. When you enter the new income on ACCESS, she fails the income test. You approve the ELIG result on January 11. Even though she has lost eligibility for both Medicaid and VHAP, she retains managed care coverage as VHAP through April 30. The ACCESS-generated notice will explain the future end date of coverage. In April, ACCESS will generate another letter reminding her of the closure and advising her to reapply if her circumstances have changed.

* If a client loses eligibility for both Medicaid and VHAP during the guaranteed period or the guaranteed period ends for one of the reasons at M101, the guarantee no longer applies if the client is later found eligible for assistance and managed care during that established six-month period.

Example: The guaranteed period is from November through April.

In December, the client is incarcerated for two months so eligibility and the guaranteed period end.

In February, the client reapplies and is found eligible effective February 1.

The client may return to the same managed health care plan, but is not guaranteed coverage.

* When a new recipient joins a household that is in a six-month guaranteed period, he or she begins an individual six-month guaranteed period.

Example: Joan and her children are in a guaranteed six-month period from January through June. In

April, she is married to someone who was not previously eligible. Her husband begins eligibility April 1 and has guaranteed coverage through September 30. The review period for the household does not change.