MODIFIED ADJUSTED GROSS INCOME (MAGI) APPLICATION PROCESSING (42 CFR 435.906, 42 CFR 435.907)

This section provides guidance on processing applications for MAGI groups.

An in-person interview is NOT required as part of the application process. **ONLY** schedule a face-to-face interview if requested by the household or authorized representative (A/R).

D-100 OVERVIEW

Accept any application form designated for medical assistance programs. Applications **must** be accepted via:

- Internet;
- Telephone;
- Mail;
- Fax; or
- In person.

Applications can be submitted online at the Division's web page www.dwss.nv.gov. The agency also accepts telephonic applications through their customer service call centers and field offices:

- Northern Nevada: 775-684-7200
- Southern Nevada: 702-486-1646
- Statewide: 877-543-7669

Paper applications completed by the customer service center and field offices over the telephone with the customer must be documented to indicate a telephone signature was obtained with Amazon Web Services (AWS).

Once completed and the telephonic signature is obtained with AWS, a signed and date-stamped~~, a~~ copy of the paper application must be mailed to the customer as confirmation an application was received by the Division.

D-101 APPLICATION

An application must contain:

- The applicant's name;
- Address; and
- Signature.

The Division must accept applications signed by:

- An adult who has a parent/dependent child (under the age of 19) relationship or tax relationship to the applicant(s);
- An A/R;
- If the applicant is a minor or incapacitated, someone acting responsibly for the applicant;
- An emancipated minor; or
- The spouse/domestic partner of an individual.

Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission are acceptable.

Applicants who cannot sign their name must have their mark witnessed by at least one (1) other person. Applicants with no ability to understand what they are signing must have a competent adult family member sign for them. **Example:** [customer name] by [family member name].

If there are no family members or the existing family members do not wish to assist the applicant, the hospital, nursing home or county agency social service staff may sign on behalf of the applicant. **Example:** [customer name] by [the hospital, nursing home or county agency social service worker name] **In this case, a public guardian referral is required.**

When applicants are unable to designate an A/R and there are no family members or the existing family members do not wish to assist the applicant, the hospital, nursing home or county agency social service staff may designate themselves as an authorized representative.

The hospital, nursing home or county agency must make a reasonable effort to contact family members of the applicant for information to help determine eligibility. The hospital, nursing home or county agency must provide the names and addresses of family members they contacted or tried to contact. The case manager will send Form 2534 Relative Inquiry Letter to the relatives advising of the application, the hospital, nursing home or county A/R and request any eligibility information to assist in processing the case.

D-101.1 Unsigned Applications

An application which is not signed by the head of household, or an A/R is an inquiry only. Staff should make a reasonable attempt to contact the Head of Household (HOH), or A/R to obtain a signature telephonically via all phone number(s) available on the application and the AMPS system. If no contact is made, do not date stamp the application, it is an inquiry only. The application is incomplete and should not be retained.

NOTE: Unsigned applications received for a case with open benefits must be retained and evaluated for changes only.

D-101.2 No Program Selected

If the application is signed but no program is selected, staff must register and evaluate all applicable Medicaid programs for all listed household members, using prudent person principle.

If any household member is over age 65 and/or lists any disability, impairment, need for additional services, or institutionalization, the Division must evaluate for Medical Assistance for the Aged, Blind, and Disabled (MAABD).

D-101.3 No Mailing Address Provided

If the application is new with no open programs, and no mailing address is provided, staff must not date stamp nor register the application until the mailing address is obtained. Staff must attempt to contact the household via all available phone number(s) to obtain the mailing address. If contact is not made, it is an inquiry only and should not be retained.

For redeterminations, the address is pre-printed on the form. If the customer does not state their address has changed and there is no reason to question the mailing address on file, including for customers who have previously used General Delivery, the mailing address on file is considered valid and the redetermination should be evaluated following normal eligibility guidelines. This includes redeterminations where the customer chooses to use other application methods instead of the Redetermination of Medical Eligibility form - NRD1, as they are known to the system, and they currently have an open ongoing case.

NOTE: It is not allowable to simply enter General Delivery for a mailing address when the information is missing on the application. A General Delivery address should only be entered when provided by the customer or A/R. Staff should make every attempt to collect the information, but if unsuccessful, it is an inquiry only and should not be retained.

D-105 REQUESTS FOR AN APPLICATION

The applicant or their representative may request an application by contacting customer service, the district office or downloading an application from the Division's web page at dwss.nv.gov. Applicants should be encouraged to visit the website to complete an online application for medical assistance. See D-125 Registration of the Application for more information.

Form 2960, Application for Health Insurance should be provided to anyone requesting medical assistance for non-elderly, non-disabled individuals and families.

Form 2920, Application for Assistance to Aged, Blind and Disabled (MAABD) should be provided to anyone requesting medical assistance for aged, blind or disabled individuals.

Individuals applying for medical assistance under the specialized groups should apply using the specialized applications for each group. (See Medical Assistance Manual D-200 Specialized Group Application Processing).

Accept any approved medical application form, if the application requires additional information, contact the household to obtain the information needed to process the application for the appropriate medical category. If unable to contact the applicant, mail an Insufficient Information Form requesting the additional information.

D-110 APPLICATION ASSISTANCE (42 CFR 435.908)

If an individual needs help completing the application or redetermination, a volunteer or staff member must help. Anyone helping complete the application form must initial the parts completed or sign the form showing they helped complete it.

D-115 FILING THE APPLICATION

The application date is the day the district office receives an application form containing the applicant's name, address, and appropriate signature.

Applications received by the Division outside of normal business hours, through electronic sources such as Access Nevada, the Exchange, or local office drop boxes, are considered received and date stamped the next business day. This is the first (1st) day these applications are available to the Division for processing.

D-120 WITHDRAWAL OF APPLICATION

An individual may voluntarily withdraw an application any time before a case decision is made.

D-125 REGISTRATION OF THE APPLICATION

All paper applications for medical assistance, received via fax, mail, drop-box, telephonically and in-person are documented and date stamped by the Division. These applications will be electronically scanned and registered timely for an eligibility determination.

Applications for multiple programs submitted online through Access Nevada will produce a PDF document for Medical, Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF). These PDF documents are application summaries only and may not be re-printed and used as a new paper application.

D-130 DUPLICATE ASSISTANCE SCREENING

All household members requesting or applying for initial or continued assistance must be screened by social security number and name to avoid duplicating assistance.

Assistance can only be provided from one (1) Nevada Medicaid/Children's Health Insurance Program (CHIP) program at a time. Nevada Medicaid/CHIP Programs include:

Family Medical Coverage (FMC)	**Infants and Children under age 19; Parent/Caretaker Relative; Pregnant Women and Postpartum; Childless Adult; Transitional Medicaid; Post Medical, Emergency Medicaid; Omnibus Budget Reconciliation Act (OBRA)**
Nevada Check Up (NCU)	**Nevada Check Up**

Division of Child and Family Services

Medicaid

Specialized Groups	**Breast and Cervical Cancer; Aged Out of Foster Care; Children in the Custody of a Public Agency, Justice Involved Re-Entry**
MAABD	**Medical Assistance to the Aged, Blind & Disabled**

When moving a customer to another household, do not post downgrades to eligibility after cut-off for the next month, Medicaid Management Information System (MMIS) cannot recognize this action, and the eligibility will not be terminated.

Note: A system notification is sent to Healthcare.gov when an individual is enrolled in Medicaid. Healthcare.gov will notify the individual of disenrollment in Advanced Premium Tax Credits (APTC) received through Healthcare.gov.

D-135 TIME FRAMES (42 CFR 435.912)

Process MAGI based eligibility determinations no later than the 45th day from the application date.

D-140 PRE-ELIGIBILITY VERIFICATION

If customer statement indicates ineligibility, deny the application based on customer statement and notify the household. There is no need to verify the information.

D-140.1 Non-Financial

- **Citizenship** – Citizenship or immigrant status *must* be verified prior to approval. Citizenship is verified electronically through the federal hub or using current case information. Refer to Medical Assistance Manual (MAM) C-400 Citizenship and Identification Requirements for citizenship verification requirements including additional procedures on case approvals using the "Reasonable Opportunity" policy when electronic information is unavailable to the Division.

- **Social Security Number** – Verified via NUMIDENT. When a discrepancy exists follow procedures outlined in MAM C-200 Social Security Numbers for SSN discrepancies.

- **Residency** – Accept customer statement for residency. When a discrepancy exists in the current case file, contact the household or a collateral contact to clarify circumstances and document the information. See MAM C-100 Residence Requirements for residency verification requirements.

- **Age/Date of Birth (DOB) –** Verified via NUMIDENT. Follow MAM C-200 Social Security Numbers if a NUMIDENT discrepancy exists. If no data source is available accept customer statement for age.

- **Household Composition** – Accept customer statement for verification of household composition.

- **Pregnancy** – Accept customer statement for pregnancy. When the customer does not provide an expected due date (EDD) on the application, contact the customer to obtain the EDC. If unable to obtain an EDC via phone, staff should update the PREG record and the unborn' s MEMB screen with a due date eight months out from the date of application and process the case.

  Medicaid Assistance Applications received from the Exchange will not have an EDC on the PDF as the Exchange does not ask this question. The Division systems require an EDC entered to process correct eligibility for pregnant women. A default date of 12/31/9999 will be entered and must be updated by staff during processing.

  Note: Currently the system does not create an AMPS task when the EDC has passed, however staff should still receive an alert in AMPS/NOMADS. When subsequent applications are received, staff should review and verify the PREG record and unborn' s MEMB details are accurate and update if necessary.

- **Caretaker Relative** – Accept customer statement for verification of relationship.

- **Domestic Partnership** – Accept customer statement for verification of relationship.

D-140.2 Financial

Verify current monthly income using available electronic data sources. When an open TANF/SNAP case exists, always use that data source as a primary verification. If new income is reported on the application, follow TANF/SNAP verification rules.

If no data source is available, request verification of current monthly income from the applicant/household. The request should include the 30-day period beginning with the day prior to the date of application and extending back 30 calendar days.

Note: When a 30-day best estimate does not provide a clear presentation of the household's income, a 60 day best estimate should be evaluated.

D-145 POST ELIGIBILITY VERIFICATION

If all factors of eligibility (Financial & Non-Financial) required during the Pre-Eligibility process are verified, staff must complete case processing and determine Medicaid eligibility.

When there is additional information reported on the application but not required for a Medicaid determination, send an Insufficient Information Form after posting the case and allow the applicant 10 days to provide the requested information. Post Eligibility Verifications can include:

- **Third Party Liability –** when the application indicates insurance coverage is available at no cost to the customer send an Insufficient Information Form requesting the customer to enroll.

- **Tribal Enrollment** – when information on the application indicates a child eligible for Nevada Check Up (NCU) is a member of an American Indian tribe, send an Insufficient Information Form requesting verification of American Indian descent.

D-150 VERIFICATION SOURCES

Electronic verifications **must** be used when available **and** prior to sending an Insufficient Information Form requesting any paper documentation.

When an open TANF/SNAP case exists, always use that data source as a primary verification. If new income is reported on the application, follow TANF/SNAP verification rules.

Electronic data sources include but are not limited to:

- TANF and SNAP open case file verification
- State Online Query (SOLQ) - Income, Citizenship, residency if questionable
- Unemployment Insurance Benefit (UIB) – Unearned income
- Federal data services hub (FHUB)/United States (US) Citizen – Citizenship information received from VLP (Verify Lawful Presence) in FHUB
- Systematic Alien Verification for Entitlement (SAVE) – Immigration status
- ANSRS – Employment income and vital statistics
- BENDEX/ State Data Exchange (SDX) – Social Security income

Other data sources include but are not limited to:

- Collateral contact – document name, number and information received.

Examples:

Customer reports earned income. Work income can be viewed in FHUB when customer has an open SNAP case with a 30-day history from three (3) months prior. Use the FHUB.

Customer reports earned income. The only data source available is Automated Nevada Server-based Reference System(ANSRS). If the quarterly income from three (3) months ago is the same employer and the income amount is reasonably compatible with the customer statement of income, then use the ANSRS data as verification.

D-150.1 Reasonable Compatibility (42 CFR 435.952)

When processing a new application, if the information received from a data source is relatively consistent and does not vary significantly from the customer stated information, it is considered reasonably compatible. Income verification obtained through a data source is reasonably compatible with information provided by the individual when both are either above or both are below the

applicable income standard.

When there is a discrepancy between the customer statement of income and the data source, certain households are allowed an additional opportunity to provide verification of income. Follow the reasonable compatibility rules to determine when to allow the household an opportunity to provide additional verifications.

a. The data source indicates income is under the income limit; **and**
the customer attested income is under the income limit;

- Consider the income verified.

b. The data source indicates income is over the income limit; **and**
the customer attested income is under the income limit; **and**
the data source is over the income limit for the assistance unit size by less than $225;

- Contact the customer to obtain a reasonable explanation and verification of income discrepancy.

If unable to provide verification showing their income is below the income limit, deny the application using the data source as verification.

c. The data source indicates income is over the income limits; **and**
the customer attested income is under the income limit; **and**
the data source is over the income limit for the assistance unit size by greater than $225;

- Deny the application based on the data source verification.

d. There is no data source available; **and**
the customer attested income is below the income limit.

- Request the individual/household to verify income prior to enrollment.

Example: 138% Federal Poverty Level (FPL) for a household of three (3) is $3,065

- Application indicates monthly income of $2,950 month for a household of three (3).
- ANSR reports quarterly wages of $8,751/3= $2,917 month. (No other more current data source is available.
- The data source verification is over the income limit by less than $225-($3,065-2,917= $148) therefore the customer is given a reasonable opportunity.

Contact the household to obtain reasonable explanation and verification of income.

D-150.2 MAGI Discrepancy with Supported State-Based Marketplace Applications (42 CFR 435.603(h)(3)(i))

Applications for Medicaid received through the Exchange are sent to the state when the applicant's stated annual income is determined to be below 100 percent of the FPL. This type of income is attested income provided by the applicant to the Exchange and may or may not be verified. The information is populated on the application as verified income and the Exchange will attempt to match this information with approved electronic data sources via the Exchange datalink with the Federal data services hub (FHUB). However, the application does not reflect whether or not the attested information was verified.

If an individual is determined to be ineligible for Medicaid due to current monthly income budgeting **and** the application for the individual was received from the Exchange stating that the income is below 100 percent FPL, Medicaid financial eligibility will be determined in accordance with the annual income budgeting method (See MAM E-135 Application of Modified Adjusted Gross Income).

Income used by the Exchange must be reasonably compatible to the current MAGI monthly income as verified by the Division. If a discrepancy between the Exchange's stated annual income and the current of MAGI monthly income are not reasonably compatible or the difference explainable, additional verification of the stated annual income will be needed before an eligibility determination can be made.

Example: It is reported on the Exchange application that the customer expects to make $22,000 this year. MAGI budgeting shows excess income of $2,500/month or $30,000 annually. The $8,000 discrepancy between the Exchange and MAGI must be verified. The customer will need to provide additional verification to explain the difference in income.

Verifications may include (not all inclusive):

1. Copy of seasonal work contract
2. Migrant farmer contract
3. Statement from Employer

D-155 PENDING INFORMATION

Give the applicant an Insufficient Information Form, detailing what verifications are needed, allowing the household at least 10 days to provide requested verifications. *When the due date falls on a weekend or holiday, the due date is the next working day.* A copy of the Insufficient Information Form must be stored in the case file with the current application, reflecting the verification request due date**.**

If information is not provided within the time period given, deny the application or terminate assistance allowing adverse action. Do not deny individuals if the pending information is not used in that individual's eligibility determination.

Example: Household consists of grandma, adult child and grandchild. Grandma claims all members on her taxes. Household fails to provide grandmother's income verifications. The grandchild would not be denied because the grandmother's income is not used in her eligibility determination.

If information is provided prior to the denial/termination action being taken, process the case using the verifications.

Note: When proof of pregnancy ending/birth of child is requested but not provided, and no information is available through collateral contact or approved electronic data source, the ongoing eligibility of the pregnant woman must be re-evaluated for all other Medicaid coverage groups (without the unborn member) prior to termination. The unborn member record(s) and pregnancy information should be updated to reflect the unborn as no longer present in the household (see MAM D-520 Questionable Information and/or Unreported Changes).

D-155.1 Future Actions

If staff has information about anticipated changes in circumstances that may affect ongoing eligibility of a case, they must re-evaluate eligibility at the appropriate time based on such changes. Create a future action for the date of the anticipated change to affect the change timely.

Example: Critical age changes, birth of a child(ren), seasonal employment.

D-160 CERTIFICATION PERIOD

Medical assistance is approved ongoing from the first (1st) month of eligibility. Individuals remain eligible for Medicaid until information is received indicating they no longer meet eligibility criteria. A redetermination of eligibility must be completed at least every 12 months.

D-160.1 Nevada Check Up

NCU is approved effective the month following the month of approval. If processed after cut-off the effective date is the second (2nd) month after the month of approval.

Approve NCU for 12 months from the enrollment date. Child(ren) are entitled to 12 months continuous eligibility.

An enrollee's 12-month continuous eligibility may be terminated for the following federally recognized exceptions:

- The child attains the age 19;
- The child or child's representative requests a voluntary disenrollment;
- The child is no longer a resident of the State;

- The Division determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of the Division's error or fraud, abuse, or perjury attributed to the child or the child's representative;
- The child dies;
- The child becomes eligible for Medicaid; or
- Failure to pay premiums.

Note: If a child in a continuous eligibility period no longer has a satisfactory immigration status, Medicaid benefits will be limited to emergency medical coverage for the remainder of the continuous eligibility period.

When a household has members eligible under NCU and Medicaid, the 12-month certification period is effective the month of approval.

D-160.2 Newborns (AKA OBRA)

OBRA eligibility is approved for 12 months from the child's DOB if their mother was receiving Medicaid in the same month of the child's birth. These children are entitled to 12 months continuous eligibility, as long as they remain a Nevada resident (see MAM B-120.1 Deemed Newborn Children).

When approving OBRA coverage, staff need to manually change the redetermination (RD) date to the month the child turns age one (1).

D-160.3 Transitional Medicaid

Transitional Medicaid eligibility is approved for 12 months continuous eligibility, as long as they continue to meet eligibility criteria as indicated in MAM B-130 Transitional Medicaid Coverage.

When approving Transitional Medicaid coverage, staff need to manually change the RD date to 12 months from the date the case rolls to Transitional Medicaid.

D-165 NEVADA CHECK UP PREMIUMS

Families with children enrolled in NCU are charged a quarterly premium based on the family's monthly taxable income. Premiums are charged per family, not per child.

NCU premium payments must be paid using a check, money order, Visa, Mastercard or Discover Card. Customers should be advised to include their Unique Person Indicator (UPI) number on the payment.

- Cash payments are not accepted
- Payments are accepted via:

- Online, visit www.e-billexpress.com/ebpp/NVMedicaid/;
- Over the phone, call 775-684-3660; or
- Mail to:
  Nevada Check Up Program
  PO Box 847346
  Los Angeles, CA 90084-7346

Late payments paid in-person will be accepted at the following locations:

Carson City
1000 E. William St. Ste. 118
Carson City, NV 89701
(775) 684-3660

Elko
1010 Ruby Vista Dr. Ste. 103
Elko, NV 89801
(775) 753-1191

Las Vegas
1210 S. Valley View Blvd Ste. 104
Las Vegas, NV 89102
(702) 668-4200

Reno
745 W. Moana Ln. Ste 200
Reno, NV 89509
(775) 687-1900

Households with children who are Native American and Alaskan Natives are not charged a monthly premium. Children of American Indian descent are exempt from the premium. Verification of American Indian descent must be provided in order to waive the premium. The child's tribal affiliation should be entered on the Members BAP.

Premiums are calculated by the system and transmitted for collection. Disenrollment will occur if a household is 60 days or two (2) full months past due. Staff will be notified with a task in the system when non-payment has occurred. See D-500 Changes for processing non-payment.

D-170 CASE DOCUMENTATION (42 CFR 435.913)

Staff-must include in each individual's case record facts to support the decision on the application. Documentation must be clear and concise. Provide enough information so anyone reviewing the case can determine the reason, logic and accuracy of the case manager's decisions and actions.

D-170.1 Case Records (NRS 239.080, NRS 230.125)

The Division must maintain case files in accordance with the state's record retention schedule.

Records must be maintained for 37 months after the case closure date.

D-175 PRIOR MEDICAL COVERAGE

Prior medical coverage is available for up to three (3) months prior to the application month if the individual requesting the coverage meets all eligibility requirements for that month. See MAM A-115 Prior Medical.

D-180 REINSTATEMENTS

Reinstatements are allowed for the following reasons:

- The household provided verification within 10 days from date of denial.
- The household provides verifications prior to the termination action being taken.
- The customer provides RD form and all verifications within 90 days from termination of RD. (See MAM D-400 Redeterminations)

Reinstatements for other reasons are made at the discretion of the social services manager (SSM) or supervisor.

D-185 "PRUDENT PERSON" PRINCIPLE

The policies included in the **manual** are rules for determining eligibility. It is impossible to foresee and give examples for all situations; therefore, staff are encouraged to use reason and apply good judgment in making eligibility decisions when rare and unusual situations are encountered. Reasonable decisions made by staff based on the best information available using good judgment, program knowledge, experience, and expertise in a particular situation are referred to as prudent person principle.

Document the rationale used to make a decision and any applicable **manual** references and policy interpretations. Follow local office procedures for obtaining an interpretation from Eligibility and Payments (E&P) Program Specialists, when it is impossible or inadvisable to follow the prudent person principle because of a lack of information or program knowledge.

Note: All questionable circumstances should be referred to Investigations and Recovery (I&R) following applicable I&R referral processes.