	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES MEDICAID POLICY MANUAL			
	Chapter:	**2700**	**Effective Date:**	**May 2023**
	Policy Title:	**Family Medicaid Miscellaneous Changes**		
	Policy Number:	**2716**	**Previous Policy Update:**	**MT 68**

REQUIREMENTS

Other changes may occur which may require action. Evaluate reported changes for necessary action.

BASIC CONSIDERATIONS

Mass Changes

Mass changes affect all or a large number of AUs receiving benefits. These changes may include the following:

- adjustments to income limits
- adjustments to dependent care deductions
- cost of living adjustments to SSA, SSI, VA, and other benefits
- other changes based on legislative or regulatory actions.

Mass changes are generally completed by system changes and require no worker intervention. Adequate notice is required.

Cases affected by the mass change but not updated by the system may require the worker to initiate a change. A list is generated to notify the worker which cases will not be updated in the mass review so that the worker may take appropriate and timely action.

Closure: AU Request Closure

Document the following:

- the reason for the closure
- the date the closure is requested.

Closure: AU Request Closure

Terminate ongoing benefits after giving timely notice.

NOTE: If the request for closure is in writing, only adequate notice is required.

EDD Contact on Pregnant Women

Complete the following procedures in contacting a pregnant woman each month beginning with the month prior to the EDD:

- Contact the pregnant woman by telephone, letter or face-to-face.
- Establish by the A/R's statement that the pregnancy continues, reminding the pregnant woman to notify the agency when the pregnancy terminates. Also, remind the pregnant woman of her right to apply for TANF 45 days prior to the expected date of delivery.
- Continue to contact the pregnant woman each month until the pregnancy terminates.

If she reports her pregnancy has terminated but is now pregnant, do not change the EDD information. Terminate the pregnancy by entering termination date on the current pregnancy record. Create a new pregnancy record with the new EDD reported and Circumstance Change Date based on reported on date to prevent billing and medical service issues.

When a pregnancy terminates, continue Medicaid through the 12-month extended postpartum period. Refer to Section 2174, Deemed Newborn Medicaid.

Processing the 12-month Extended Postpartum Period

Complete the following procedures to process the 12-month extended postpartum period Medicaid when pregnancy terminates for a Medicaid eligible pregnant woman.

- Determine date of termination.
- Start the 12-month count beginning the month after termination of pregnancy.
- Continue Medicaid for the pregnant woman through the end of the 12th month .
- Begin a CMD by the 12th month of the postpartum period and complete the process prior to the end of the 13th month.
- If Medicaid eligibility does not continue, terminate Medicaid on the pregnant woman and refer to the Federally Facilitated Marketplace (FFM). Send timely notice.

Processing Newborn Medicaid

When a pregnancy terminates with the birth of a child, use the following procedures to process eligibility for the newborn:

- Determine if Parent/Caretaker with Child(ren) eligibility exists.

- If ineligible for Parent/Caretaker with Child(ren), establish that mother was eligible for and receiving Medicaid on the day the child was born. Refer to Section 2174, Deemed Newborn Medicaid for the definition "receiving Medicaid on the day the child was born".

- Approve Deemed Newborn Medicaid for the month of birth and ongoing pending contact with the parent or caretaker.

- Continue ongoing Medicaid for the child if eligible. If ineligible, complete a CMD.

- Discuss third party liability and complete Form DMA-285, Third Party Liability, if necessary.

- Begin a CMD in the 12th month of Newborn eligibility and complete the process by the 10th of the 13th month of eligibility.

- If a child is eligible under another COA, process as required. Complete a renewal, administrative, alternate, or standard, to determine all points of eligibility. If eligibility continues, approve the child under the appropriate COA.

If eligibility does not continue under any COA, provide a termination notice.

Children Under 19 Years of Age Medicaid Recipient Reaches an Age Limit

Use the following procedures when a Children Under 19 Years of Age Medicaid recipient reaches an age limit.

- For a child receiving inpatient services in the month s/he reaches an age limit, refer to Section 2182, Children Under 19 Years of Age.

- Complete a new budget using the appropriate Children Under 19 Years of Age income level for the child's age.

- If eligibility continues, send a notice to inform the AU of the change in eligibility.

- If over the Children Under 19 Years of Age income limit, refer the AU to PeachCare for Kids® or the FFM.

NOTE: When a Children Under 19 Years of Age child reaches the 19-year age limit, complete a CMD. Begin this process in the month prior to the individual's 19th birthday and complete the CMD by the 10th of the last month s/he will be 19 years old.

Changes in MN Case During the One Month Budget Period

Use the following procedures to re-calculate eligibility for Medicaid when an A/R reports any of the following changes in a MN case during the one-month budget period:

- an increase or decrease in income

- a change in BG size

- additional medical expenses
- an increase or decrease in resources
- a change in dependent care expenses

NOTE: The result of any of these changes may cause the AU to become eligible earlier in the budget period month, may cause the case to go from eligible for Medicaid to spenddown status, or may increase or decrease the spenddown.

- Request verification of the change if required.
- Determine the actual income that has been received and/or the BG size for the budget period.
- Anticipate income and expenses for the remainder of the budget period.

Changes in MN Case During the One Month Budget Period (cont.)

- Determine BG composition for the budget period.

NOTE: If a BG member was living in the home at any time in the month, count this individual in determining the BG size.

- Re-calculate eligibility.
- Subtract any allowable deductions from the total income
- Subtract the MNIL from the net income.
- If the result is equal to or less than the MNIL, approve or continue de facto eligibility.

NOTE: If this change results in de facto eligibility, the case becomes eligible for Medicaid in the month the change occurred.

- If the result exceeds the MNIL, this is the spenddown amount. Apply any incurred medical expenses chronologically to this spenddown. If spenddown is met, approve MN for the AU on the day spenddown is met. Provide Form 400, as required. If spenddown is not met, return the case to spenddown status, or continue spenddown the following month.
- Notify the AU of any action on the case.

Other Changes in a MN Case

When the pregnant woman in a MN case reports termination of pregnancy, use the procedures in Chart 2716.1 to process Medicaid.

Use the chart below to determine if verification is required when an AU reports a change.

CHART 2716.1 – OTHER CHANGES IN A MN CASE

IF	THEN
the pregnant woman was correctly approved for Medicaid	provide the 12-month extended postpartum coverage.
the pregnant woman's case was in spenddown status and the bills incurred on the day of the termination of pregnancy met spenddown	verify all actual income and expenses that have been received for the budget period and anticipate income and expenses for the remainder AND recalculate the budget and all incurred medical expenses in chronological order AND approve Medicaid the day spenddown is met through the 12-month extended postpartum period, even if it extends beyond the budget period AND Provide Form 400 as needed. **NOTE:** If spenddown is met on the pregnancy termination date or prior, the pregnant woman is eligible for Medicaid and the child is eligible for Deemed Newborn coverage.
if the mother is or becomes Medicaid eligible	approve the child for Deemed Newborn coverage.

CHART 2716.1 – OTHER CHANGES IN A MN CASE

If an A/R submits an unpaid medical expense that was incurred during or prior to the budget period but after the budget period has expired, apply the bill to the spenddown if the following two conditions are met:

- spenddown for the budget period will be met or adjusted by allowing this expense

AND

- the bill is presented within three months of the expired Budget Period.

If these conditions are met, follow the procedures in this chart.

NOTE: If the three-month time limit has passed, allow the bill in any current or future budget period if the BG member is still legally obligated to pay the bill and there is no Third-Party Liability coverage available.