OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

DISCONTINUANCE OR REDUCTION

Description: A discontinuance of Medicaid is a termination of all benefits under the program. The reduction of Medicaid is a change of benefit coverage from more extensive coverage to less extensive coverage or to an increase in the recipient's liability, i.e., a change from Community Coverage with Community-Based Long-Term Care to Community Coverage without Long-Term Care, or a change from full coverage to a spenddown.

Policy: A determination by the district to discontinue or reduce a recipient's Medicaid coverage is communicated to the recipient in a letter of intent to discontinue or reduce Medicaid. Generally, the notice is sent at least ten days in advance of the proposed action. Under certain circumstances, it is not necessary to send a notice of intent ten days in advance of the action. (See **OTHER ELIGIBILITY REQUIREMENTS** DECISION AND NOTIFICATION) Where the A/R is in receipt of both Medicaid and Public Assistance, any notice to discontinue or reduce Temporary Assistance also includes a statement advising the client of the status of his/her Medicaid eligibility.

References:

SSL Sect.
366
366-a

Dept. Reg.
358-3.3
358-4.1
360-2.3
360-2.6
360-2.7
360-2.8
360-2.9

ADMs
04 OMM/ADM-6
97 OMM/ADM-2
89 ADM-21
83 ADM-27
81 ADM-55
80 ADM-19

Interpretation: A Medicaid case is discontinued because of the recipient's ineligibility for continued assistance, failure to cooperate, permanent removal from the district or other factors which affect continued eligibility. Generally, a letter of notification

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is sent (See **OTHER ELGIBILITY REQUIREMENTS** DECISION AND NOTIFICATION), at least 10 days in advance of the proposed action, to the recipient advising him/her of: the action to be taken; the effective date of the action, the reason(s) why the action(s) is/are being taken; the supporting law or regulation; the client's right to request a conference with a representative of the district; and the right to a fair hearing. If the recipient requests a fair hearing between the date of the notification and the date of the proposed action, Medicaid is continued without reduction until the fair hearing decision is rendered.

A reduction in Medicaid coverage also requires that a letter of notification be sent at least 10 days in advance of the proposed reduction. The letter of notification advises the client: that his/her Medicaid is being reduced; the effective date of the action; the reason why the action is being taken; the supporting law or regulations; the recipient's right to a conference with a representative of the district; and the right to a fair hearing. If the recipient requests a fair hearing between the date of receiving the notice and the date of the proposed reduction, Medicaid is continued without reduction until the fair hearing decision is rendered.

When an A/R is in receipt of Temporary Assistance and Medicaid or SSI cash and the cash benefit is discontinued, a separate determination for Medicaid is completed by the end of the calendar month following the month in which cash assistance is terminated. The Notice of Intent to Discontinue Temporary Assistance contains a separate statement advising the client of the status of his/her Medicaid: continued until a separate determination can be made; discontinued and the reasons why; or continued until the next recertification. When an SSI cash benefit is discontinued, and there is adequate information in the local district’s records, the recipient's eligibility is determined without contacting the recipient. The recipient is notified of the eligibility decision. When Medicaid eligibility cannot be determined due to inadequate information, the recipient is contacted and required to provide the necessary information. Medicaid is continued pending the receipt of the information. The recipient is given 30 days to provide this information.