COMBINED MEDICAID 0-3
Introduction

Supersedes: FMA 0-3, (01/01/06) and MA 0-3 (09/01/98)

Reference:

Overview: Title XIX of the Social Security Act is a federal-state matching entitlement program that pays for medical assistance for certain vulnerable and needy individuals and families with low incomes and resources. Medicaid became law in 1965 as a jointly funded cooperative venture between the federal and state governments to assist states furnishing medical assistance to eligible needy individuals. Medicaid is the largest program funding medical and health-related services for America's poorest people.

Within broad national guidelines established by federal statutes, regulations and policies, each state:

1. Establishes its own eligibility standards;
2. Determines the type, amount, duration and scope of services;
3. Sets the payment rate for services; and
4. Administers its own program.

Medicaid policies for eligibility and services are complex, and vary considerably even among similar-sized and/or adjacent states. Thus, a person who is eligible for Medicaid in Montana may not be eligible in another state; and the services provided in Montana may differ considerably in amount, duration, or scope from services provided in neighboring states. In addition, Medicaid eligibility and/or services within a state can change during the year.

RESPONSIBILITY FOR PROGRAM ADMINISTRATION:

Medicaid is administered in joint cooperation by Federal and State governments. This is accomplished cooperatively with the Field Offices of Public Assistance and processing centers providing the day-to-day client contact under state policies. The Federal government provides guidelines for state operations.

USING THIS MANUAL:

The policies in this manual are intended as a guide for eligibility determination and are written within the Centers for Medicare and Medicaid Services (CMS) imposed limits. The policies are intended to be sufficiently flexible to allow eligibility staff to exercise reasonable judgment in processing Medicaid eligibility.

In this regard, the concept of the “prudent worker” is helpful. The term refers to the reasonableness of the judgments made by an individual eligibility staff member in a given situation. In a court case, a person charged with negligence will try to show that his actions were the actions that any reasonable or “prudent” person would take in the same circumstances.

When finalizing an eligibility decision, eligibility staff should be conscientious about making a decision that is reasonable, based on his or her knowledge of and experience with the Medicaid programs.

If the eligibility staff member encounters a problem in a specific case that is felt to be outside the ordinary policy and procedure, the problem should be referred first to their supervisor/field operations manager, and then to the Service Desk.

If the problem applies to only a specific case or to a limited number of cases and is generally covered by existing policy, the eligibility staff member makes a judgment that is defined as reasonable and prudent. Case notes are documented with the actions taken.

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