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MEDICAID ELIGIBILITY

INTRODUCTION

The Medicaid program was authorized by federal legislation in 1965 through Title XIX of the Social Security Act. Medicaid provides health care access to low-income persons who are age 65 or over, blind, an adult with a disability, families with dependent children, pregnant women in poverty, refugees and children in state care. Missouri's Medicaid program is funded by multiple sources: the Federal Government, Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) and Missouri taxes. The Department of Social Services (DSS), MO HealthNet Division (MHD) is the designated state agency that administers the Medicaid program in Missouri.

PURPOSE

A Home and Community Based Services (HCBS) participant must have Medicaid benefits to qualify for HCBS. This policy will explain eligibility, special circumstances, definitions and Medicaid Eligibility (ME) codes related to various Medicaid benefits.

ELIGIBILITY

Individual eligibility for Medicaid benefits is determined by DSS, Family Support Division (FSD) based on specific program eligibility requirements.

HCBS is authorized by the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS). HCBS is available to individuals who meet specific eligibility requirements including, but not limited to:

- Determined eligible for Medicaid benefits that reimburse for HCBS
- Agreeable to participate in a face-to-face assessment and development of a person-centered care plan (PCCP)
- Determined to meet nursing facility Level of Care (LOC)
- Assessed to have an unmet need(s) which can be met through the authorization of HCBS
- Assessed to meet the eligibility requirements for authorized service(s) as described in Chapter 3

Potential participants must have active Medicaid benefits prior to an initial referral for HCBS with the following exceptions (see Special Circumstances):

- Unmet spenddown liability if eligible for Home and Community Based (HCB) Medicaid
- Qualified Income Trust (QIT)

- Division of Assets Specified
- Low Income Medicare Beneficiary 2 (SLMB 2)

SPECIAL CIRCUMSTANCES

HOME AND COMMUNITY BASED MEDICAID (HCB MEDICAID)

HCB Medicaid eligibility rules provide for a higher income threshold for individuals who meets the requirements for and have a need for Aged and Disabled Waiver (ADW) services. Determination of HCB Medicaid eligibility requires coordination between FSD and DSDS. The IM-54a shall be used to promote communication between the agencies regarding HCB Medicaid eligibility requirements. The IM-54a shall be uploaded into the participant's electronic case record. DSDS staff shall review HCB Medicaid eligibility during the initial assessment, reassessment and PCCP maintenance process.

SPENDDOWN COVERAGE

Individuals who meet Medicaid eligibility requirements, but have income over the monthly limit, may meet eligibility for spenddown coverage. A spenddown is a monthly premium payment that participants must meet before Medicaid benefits become active.

At Initial Assessment

The spenddown liability must be met for the current date before a referral for HCBS can be processed except for a participant that appears to be HCB Medicaid eligible.

Upon receipt of a referral for a potential participant that is not HCB Medicaid eligible with an unmet spenddown, DSDS staff shall inform the individual:

- A referral cannot be completed because the spenddown liability has not been met for the current date
- To contact FSD for information on Medicaid benefits
- To contact the HCBS Customer Service Center to initiate a referral once Medicaid benefits are active

Upon receipt of a referral for a potential participant that has met the spenddown for the current date, DSDS staff shall complete the initial assessment in the participant's electronic case record.

- If LOC is met, DSDS staff shall proceed with developing a PCCP and coordinating with the selected HCBS provider. DSDS staff shall inform the participant that Medicaid will only reimburse for HCBS during periods when the monthly spenddown liability has been met. The participant will be responsible to pay for the cost of any HCBS provided during periods when the monthly spenddown liability has not been met.
- If LOC is not met, DSDS staff shall proceed with the adverse action process.

At Reassessment

A participant with spenddown coverage must have met the spenddown liability for the current date or have met the spenddown liability at least once within the previous three (3) months to continue with the reassessment process. DSDS staff shall:

- Review the Medicaid eligibility within the participant's electronic case record and/or DSS systems to verify that Medicaid benefits are currently active.
  - If the spenddown liability has been met for the current date or has been met at least once within the previous three (3) months, DSDS Staff or designee shall complete the reassessment process within the participant's electronic case record.
  - If the spenddown liability has not been met for the current date and has not been met at least once within the previous three (3) months, DSDS Staff shall initiate the adverse action process.

NOTE: At the time of reassessment, DSDS staff shall determine if a participant with spenddown coverage meets the eligibility criteria for HCB Medicaid. If a participant meets HCB Medicaid eligibility criteria, DSDS staff should initiate a IM-54a.

UNMET SPENDDOWN HCB REFERRAL

DSDS staff or FSD may initiate the HCB referral (IM-54a) process for a potential participant that has not met the spenddown liability for the current date, but meets the age, income and Aged and Disabled Waiver (ADW) criteria outlined in MO's Medicaid Policy.

At initial assessment, DSDS staff shall complete the initial assessment in the participant's electronic case record.

- If LOC is met and the participant meets ADW eligibility requirements, DSDS staff shall:
  - Submit a prior authorization that includes an ADW service
  - Complete and upload an IM-54a into the participant's electronic case record
  - Submit the IM-54a to FSD HCB Processing Center
  - Communicate to the HCBS provider(s) that HCB eligibility is pending with FSD
  - If FSD returns the IM-54a denying HCB Medicaid benefits, proceed with the adverse action if appropriate
- If LOC and/or ADW eligibility is not met, DSDS staff shall:
  - Proceed with the adverse action process
  - Complete and upload an IM-54a into the participant's electronic case record
  - If FSD initiated the IM-54a, submit the IM-54 to FSD HCB Processing Center

NOTE: If FSD initiated the IM-54a and the initial assessment was not conducted, DSDS staff shall explain why there was not an assessment completed on the original IM-54a, upload the updated form and submit the form to FSD HCB Processing Center.

At reassessment or PCCP maintenance if DSDS staff or its designee identifies that a current participant with spenddown coverage meets HCB Medicaid eligibility criteria outlined in HCB Medicaid policy. DSDS staff shall:

- Complete and upload the IM-54a
- Submit the IM-54a to the FSD HCB Processing Center

When DSDS staff or its designee identifies that a current participant with HCB Medicaid no longer meets criteria or requires an ADW, DSDS staff shall:

- Proceed with the adverse action process if appropriate
- Complete and upload the IM-54a into the participant's electronic case record
- Submit the IM-54a to the FSD HCB Processing Center

QUALIFIED INCOME TRUST (QIT)

Individuals with income more than HCB Medicaid requirements may still qualify for HCB Medicaid by diverting a portion of their income into a QIT (a.k.a. Miller Trust). QIT is limited to persons needing Medicaid for nursing facility care or for services provided through the ADW.

DIVISION OF ASSETS

Division of Assets may be used to prevent spousal impoverishment. Federal law provides a way to protect a portion of assets and income for a "community spouse" whose spouse is receiving vendor nursing care or HCBS.

SPECIFIED LOW INCOME MEDICARE BENEFICIARY 2 (SLMB2)

SLMB2 is a program that can aid with Medicare premiums, co-insurance and deductibles for qualifying individuals. SLMB2 beneficiaries may be HCB Medicaid eligible if all requirements are met, however, the participant must choose which coverage (HCB Medicaid or SLMB coverage) to have.

QIT, DIVISION OF ASSETS, or SLMB2 REFERRAL PROCESS

Only FSD may initiate the HCB referral process for potential participants pursuing QIT, Division of Assets, or SLMB2.

At initial assessment, DSDS staff shall:

- Complete a paper initial assessment as the electronic system will not allow any assessment or authorization activity until FSD approves the QIT and HCB Medicaid coverage
- If the potential participant meets LOC and ADW eligibility requirements:
  - Develop a paper PCCP containing an ADW service
  - Complete and return the IM-54a to the FSD HCB Processing Center
- If FSD returns the IM-54a approving HCB Medicaid benefits:
  - Enter all assessment and authorization activity into the participant's electronic case record
  - Coordinate service delivery with the selected HCBS provider(s)
- If FSD returns the IM-54a denying HCB Medicaid benefits:
  - Proceed with the adverse action process
- If LOC and/or ADW eligibility is not met:
  - Proceed with the adverse action process
  - Complete and return the IM-54a to FSD HCB Processing Center

NOTE: If an initial assessment was not conducted, DSDS staff shall explain why there was not an assessment completed on the original IM-54a, upload the updated form and submit the form to FSD HCB Processing Center.

At reassessment or PCCP maintenance, if DSDS staff or its designee identifies that a current participant with HCB Medicaid no longer meets criteria or refuses an ADW, DSDS staff shall proceed with the adverse action process.

- An IM-54a shall be completed and uploaded. DSDS staff shall send the form to the FSD HCB Processing Center.

BLIND PENSION (ME CODE 02)

Blind Pension provides assistance to blind individuals who do not qualify under the Supplemental Aid to the Blind law and who are not eligible for Supplemental Security Income benefits. Eligible individuals receive a monthly cash grant, as well as MO HealthNet coverage.ME Code 02 will only reimburse for state plan services. Participants with ME Code 02 are not eligible for any waivered services. The electronic case record will provide an eligibility notification whenever a participant is only eligible to receive state plan services.

If a participant has a waivered service prior authorized, but Medicaid eligibility changes to ME Code 02, DSDS staff shall:

- Initiate the adverse action process
- Close all prior authorized waivered services

TICKET TO WORK HEALTH ASSURANCE (ME CODE 85)

The Ticket to Work Health Assurance (TWHA) program provides Medicaid coverage, including HCBS, for persons with disabilities ages 16 through 64 who are employed. Like spenddown coverage, TWHA coverage has a monthly premium payment that participants must meet before Medicaid benefits become active.

At Initial Assessment

The TWHA premium liability must be met for the current date before a referral for HCBS can be processed. Upon receipt of a referral for a potential participant with an unmet TWHA premium liability, DSDS staff shall inform the participant:

- A referral cannot be completed because the TWHA premium has not been met for the current date
- To contact FSD for information on Medicaid benefits
- To contact the HCBS Customer Service Center to initiate a referral once Medicaid benefits are active

Upon receipt of a referral for a potential participant that has met the TWHA premium for the current date, DSDS staff shall complete the initial assessment in the participant's electronic case record.

- If LOC is met, DSDS staff shall proceed with developing a PCCP and coordinating with the selected HCBS provider(s). DSDS staff shall inform the participant that Medicaid will only reimburse for HCBS during periods when the monthly TWHA premium liability has been met. The participant will be responsible to pay for the cost of any HCBS provided during periods when the monthly liability has not been met.

- If LOC is not met, DSDS staff shall proceed with the adverse action process.

At Reassessment

A participant with TWHA coverage must have met the TWHA premium liability for the current date or have met the premium at least once within the previous three (3) months to continue with the reassessment process. DSDS staff shall review Medicaid eligibility within the participant's electronic case record and/or DSS systems to verify that Medicaid benefits are currently active.

- If the TWHA premium has been met for the current date or has been met at least once within the previous three (3) months, DSDS Staff or designee shall complete the reassessment process within the participant's electronic case record.
- If the TWHA premium has not been met for the current date and has not been met at least once within the previous three (3) months, DSDS Staff shall initiate the adverse action process.

TRANSFER OF PROPERTY PENALTY

Participants with a transfer of property penalty have limited Medicaid benefits and are not entitled to ADW or Structured Family Caregiving Waiver (SFCW) services. FSD determines the length of the penalty if a participant has sold, traded, or given away property for which fair and valuable consideration was not received.

The transfer of property penalty does not apply to State Plan, Independent Living Waiver (ILW), or Adult Day Care Waiver (ADCW) services; therefore, Medicaid eligible participants may be authorized for those services as identified through the assessment and PCCP.

NOTE: Transferring of income into a QIT does not constitute a Transfer of Property Penalty.

MANAGED CARE

Individuals enrolled in certain Managed Care Health Plans are ineligible to receive HCBS except for State Plan Consumer Directed Services (CDS). Upon receipt of a referral for an individual enrolled in a Managed Care Health Plan where requested services cannot be authorized, DSDS staff shall refer the individual to the Managed Care Health Plan. The Eligibility tab within the participant's electronic case record provides contact information for the Managed Care Health Plan.

When an individual displays as having dual codes and one is Managed Care, DSDS staff needs to determine if the individual is "opted in" or "locked in" with a Managed Care provider before proceeding with any assessment, authorization or adverse action.

ME CODE 05 (Adult Family): Individual cannot receive HCBS. The participant will need to contact FSD to "opt out" of Managed Care Medicaid or change their Medicaid eligibility code altogether to request or receive HCBS.

Participants may "opt out" of Adult Family Medicaid (ME 05) if they meet one of the following criteria:

- Eligible for Supplemental Security Income (SSI)
- Enrolled in Special Health Care Needs Program

- Disabled and 18 years of age or younger

NOTE: This information also pertains to the ME Codes of 10, 18, 19, 21, 24, 26, 36, 37, 38, 43, 44, 45, 56, 61, 73, 74, & 75

NOTE: The electronic case record system will not allow further action on individuals who receive Managed Care on the date of request.

ME Code E2 (Medicaid Expansion) **–** Individual can only receive CDS. The participant will need to contact FSD to un-enroll from E2 in situations where there are dual codes and one code is E2, and the participant is requesting or authorized for services that E2 restricts.

Individuals with the following criteria are restricted to receive E2:

- Have active Medicare
- Age 65 or greater
- Eligible for non-spenddown Medicaid (ME codes: 05, 11, 12, 13, or 18)
- Determined as disabled through FSD Medical Review Team or Social Security Administration

Participants may "opt out" of Medicaid Expansion (ME 02) if they meet one of the following criteria:

- Eligible for SSI
- Enrolled in Special Health Care Needs Program
- Disabled and 18 years in age or younger

HCBS WEB TOOL

In the HCBS Web Tool the Eligibility section on the Participant Case Summary Screen provides information to assist with eligibility status determination. Various eligibility determination messages will display based upon eligibility for Medicaid, type of Medicaid and participant's age.

NOTE: Medicaid eligibility messages may not reflect real time information as it may take up to 48 hours for the latest information to display in the HCBS Web Tool. DSDS staff or designee shall utilize the appropriate screens within the DSS Network to verify Medicaid benefits when questions arise regarding the messages displayed within the HCBS Web Tool.

HCBS Eligibility Tab:

- Medicaid Eligibility (ME) Code
  - Prior to all HCBS (re)authorizations, the ME Code shall be reviewed to ensure the participant is eligible for specific service(s).
- Spenddown Indicator
  - The spenddown indicator only displays for spenddown participants.
    - If no is displayed, the participant has not met the monthly liability amount and is not currently eligible for Medicaid benefits.

    - If yes is displayed, the participant has met their spenddown liability amount and is currently eligible for Medicaid benefits.

- Transfer of Property
    - This field is not functional in the HCBS Web Tool. Staff shall review the LXIX screen in the DSS Network to determine Transfer of Property.
- Gross Income
    - This data is not consistently updated in the HCBS Web Tool. Staff shall access the DSS Network to determine a participant's income when needed.
- Participant Age
- Ticket to Work Premium
    - This field will display only for ME Code 85 participants and will display either paid or not paid
- Date of Death