



Missouri's Medicaid program, also known as MO HealthNet, provides health care access to low income individuals who are elderly, disabled, members of families with dependent children, low-income children, uninsured children, pregnant women, refugees, or children in state custody. Missouri Medicaid determinations are made by the Department of Social Services (DSS), Family Support Division (FSD). Complete information regarding eligibility and how to apply for benefits can be obtained by accessing the following web site <https://mydss.mo.gov/healthcare> . In addition, this web site provides a link to locate a specific Resource Center and FSD's Information Call Center.

### Medicaid (non-spenddown)

Medicaid benefits are available to persons who:

- Are United States citizens or eligible qualified non-citizen;
- Are residents of Missouri and intend to maintain residency in Missouri;
- Provide (or apply for) a Social Security Number (SSN);
- Are determined medically eligible based on:
  - Age (65 years of age), or
  - Disabled (determined to be permanently and totally disabled), or
  - Blind; and
- Do not own resources which exceed the Medicaid limit:
  - \$5,000 for an individual; or
  - \$10,000 for a couple; and
    - Married couples who have resources exceeding the \$10,000 maximum may be eligible for a Division of Assets - when only one of the couple needs Medicaid funded Home and Community Based Services (HCBS) through a Home and Community Based Waiver i.e., Aged and Disabled Waiver (ADW) or is institutionalized.
  - Have monthly income which does not exceed the non-spenddown income limit ([Medicaid Income Information](#)). Participants whose adjusted income exceeds the established guidelines as determined by FSD may be eligible for Medicaid benefits with a spenddown (see information included in this policy), and/or if age 63 or older, may be eligible for HCB Medicaid or Miller Trust benefits (see information included in this policy).

### Medicaid (spenddown)

Benefit eligibility is the same as above for non-spenddown Medicaid except participants with income in excess of the income limit will have an amount of monthly medical expenses, similar to an insurance premium or deductible, that are the participant's financial responsibility before Medicaid benefits are active.

The spenddown liability is the amount by which an individual's or couple's net income exceeds the non-spenddown income limit ([Medicaid Income Information](#)). Medicaid spenddown eligibility is determined initially by FSD. Upon determination of eligibility, the participant shall continue to be Medicaid eligible until a change in the participant's situation causes ineligibility. The participant does not have to make reapplication. Active Medicaid coverage, however, is determined on a monthly basis.

- Participants may meet their spenddown obligation by:
  - Paying the spenddown liability directly to the MO HealthNet Division (MHD) on a monthly basis which will provide active coverage for the entire month. A timely monthly payment provides the participant with ongoing Medicaid coverage; or
  - Submitting medical bills that reach the participant's spenddown liability, to the local FSD office. Active coverage will start the day the participant meets the spenddown liability and continue during the remainder of that month. On the day that the participant reaches their spenddown liability, MHD will only pay for medical services over the spenddown liability. Individuals do NOT have to pay their medical expenses before being considered as meeting their spenddown liability.
- Once determined eligible for Medicaid spenddown, a participant will be "locked-in" to receive Medicaid coverage.

### Blind Pension

The Blind Pension (BP) program was established in 1921 and is financed entirely by state funds. This program provides assistance for blind persons who do not qualify under the Supplemental Aid to the Blind (SAB) law and who are not eligible for Supplemental Security Income (SSI) benefits. Each eligible person receives a monthly cash grant as well as *state funded, rather than federally funded*, Medicaid coverage. Additional information regarding the BP program can be found by accessing the following link: <http://dss.mo.gov/fsd/blind-pension.htm>.

Benefits are available under the BP program to persons who:

- Are 18 years of age or older;
- Are living in Missouri and intends to remain;
- Are United States citizens or eligible non-citizens;
- Have not given away, sold, or transferred real or personal property in order to be eligible for BP;
- Are single, or married and living with spouse, and do not own real or personal property worth more than \$20,000. In determining the value of real or personal property, the real estate occupied by the blind person or spouse as the home shall be excluded;
- Is of good moral character;
- Have no sighted spouse living in Missouri who can provide support;
- Do not publicly solicit alms;
- Are determined to be totally blind as defined by law (up to 5/200 or visual field of less than 5 degrees);
- Are found to be ineligible for SAB (<http://dss.mo.gov/fsd/sblind.htm>);
- Are willing to have a medical treatment or an operation to cure their blindness, unless they are 75 years old or older;

- Are not a resident of a public, private, or endowed institution except a public medical institution; and
- Are found ineligible to receive federal SSI benefits.

### **Home and Community Based (HCB) Medicaid**

Medicaid eligibility rules provide for a higher income threshold for individuals who meet the requirements for and have a need for services in the ADW ([HCBS Introduction](#)). A determination must be made for need and the availability of ADW services **before** FSD can apply the higher HCB income. Therefore determination of HCB Medicaid requires the inter-agency cooperation between FSD and the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS) or its designee. HCB Medicaid coverage does not have any direct cash benefits.

- HCB Medicaid application requirements are:
  - 63 years of age or older;
  - Monthly income at or below the current HCB income standard ([Medicaid Income Information](#)).
  - Meet nursing facility level of care;
  - Is eligible to be authorized for an ADW service;
  - Meets the other eligibility requirements as outlined under Medicaid for the Aged, Blind, and Disabled.

### **Qualified Income Trust (i.e., Miller Trust)**

A qualifying income trust, such as a Miller Trust, allows an individual to place income into a trust in order to meet income eligibility guidelines for Medicaid. The trust must consist solely of the individual's income, such as monthly Social Security or pension benefits, but not resources, and must be used solely for the benefit of the individual. There are no limits on how much income can be placed in the qualifying trust. However, if amounts paid out of the trust exceed the fair market value of goods and services on behalf of the individual, then the individual may be at risk of a penalty for an uncompensated asset transfer, resulting in loss of Medicaid coverage for needed services. Additionally, amounts paid out of the trust may count as income – whether paid directly to the beneficiary or paid to purchase something on their behalf (other than medical care). This “income” must be under the eligibility level in the state and is subject to post-eligibility share-of-cost rules. Finally, the trust must specify the state will receive any amounts remaining in the trust, after the person no longer receives Medicaid benefits; up to the amount the state paid in Medicaid benefits for the Miller Trust owner.

### **Ticket to Work Health Assurance (TWHA)**

- The Ticket to Work Health Assurance (TWHA) program provides Medicaid coverage, including some HCBS, for persons with disabilities, age 16 through 64, who are employed. Resource limits are the same as for Medicaid coverage. However, the TWHA Program allows earnings.
- Participants with income above 100% of the Federal Poverty Level (FPL) will pay a premium to receive coverage. The income of the spouse is included when determining eligibility for the TWHA program. A participant whose computed gross income exceeds 100% of the Federal Poverty Level (FPL) must pay a monthly premium to participate in the TWHA program.
- TWHA eligible participants will be locked into eligibility when all requirements have been met for Medicaid coverage.

- TWAH has two components, a Basic Coverage Group and a Medically Improved Group. The Basic Coverage Group is for persons who have earnings but are determined to be permanently and totally disabled. The Medically Improved Group is for persons who have lost their eligibility for the Basic Coverage Group solely due to medical improvement. Both groups provide full Medicaid benefits.
- Upon approval, MHD will send an Initial Invoice letter, billing the participant for the premium amount for any past coverage selected through the month following approval. Coverage will not begin until the premium payment is received. If the participant does not send in the complete amount, they will be credited for any full month premium amount received starting with the month after approval and going back as far as the amount of premium paid allows.
- MHD will send a Recurring Invoice on the second working day of each month for the next month's premium. If the premium is not received prior to the beginning of the new month, the person's coverage ends on the day of the last paid month.
- MHD will not send a recurring invoice to the participant after six months of nonpayment of premium. The participant's eligibility for TWAH will remain open but the individual will not receive coverage until the premium is paid.

#### **MO HealthNet Managed Care**

- MO HealthNet Managed Care refers to the statewide medical assistance program for low-income families, pregnant women, and children under the age of 19 or, in some cases, until the age of 21. Managed Care participants receive their health care through either the Fee-for-Service delivery system or the Managed Care Health Plan delivery system, depending on where the individual lives. For Managed Care participants who are enrolled in a MO HealthNet Managed Care Health Plan, the health plan is responsible for meeting their personal care needs. These services are **not** prior authorized within the electronic case record. The electronic case record will provide contact information for the MO HealthNet Managed Care Health Plan. Although Missouri's managed care system has expanded statewide, Missourians who receive aged, blind, or disabled Medicaid benefits will not be included in the managed care system and will continue to receive services through the traditional Fee-for-Service delivery system.

#### **Supplemental Nursing Care (SNC)**

- The Supplemental Nursing Care (SNC) program is available primarily for residents of licensed residential care facilities (RCF) and assisted living facilities (ALF). The SNC program provides an actual cash payment to the resident of up to \$156 per month for RCF residents and \$292 per month for ALF residents. SNC recipients also get a \$50 personal needs allowance.