2.00
MEDICAID ELIGIBILITY

The Medicaid program, authorized by federal legislation in 1965 through Title XIX of the Social Security Act, 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 financed jointly by the Federal Government, through the Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS), and appropriations from Missouri State Government. The Department of Social Services (DSS), MO HealthNet Division (MHD) is the designated single state Medicaid agency and administers the Medicaid program in Missouri. Individual eligibility for Medicaid benefits is determined by the DSS, Family Support Division (FSD) based on specific program eligibility requirements (see Appendix 1) and by accessing the following link; http://dss.mo.gov/fsd/.

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

- Determined eligible for Medicaid benefits by FSD for payment of such services;
- Agreeable to participate in an assessment and development of a person centered care plan (PCCP);
- Determined to, at a minimum, meet nursing facility Level of Care (LOC) (see Policy 4.10);
- Assessed to have an unmet need which can be met through the authorization of HCBS as an alternative to nursing facility placement; and
- Assessed to meet the eligibility requirements for each particular authorized service, as described in Chapter 3 (i.e., age, ability to self-direct services, etc.).

Participants must have active Medicaid benefits prior to an initial PreScreen for HCBS and at the time of (re)assessment with the following exceptions:

- At initial PreScreen when the potentially eligible participant:
  - Needs a Division of Assets; or
  - Is a Specified Low Income Medicare Beneficiary 2 (SLMB 2) (see Special Circumstances).
- At (re)assessment when the participant is a Medicaid spenddown recipient (see Special Circumstances).

Medicaid Status Verification

Medicaid status verification is available upon entry into the HCBS Web Tool and/or through use of the DSS Network applications; PROD or FAMIS.

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.

'HCBS Eligibility Determination' Tab:

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 72 hours for the latest information to display in the HCBS Web Tool. DSDS 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 (see Appendix 3) – 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.

Missouri Department of Social Services Network

PROD and FAMIS are applications within the DSS Network. Their associated screens provide information regarding the participant and, if applicable, the spouse.

- Medicaid Coverage:
  - PROD application: From the LFAM screen select the type of assistance to be reviewed by entering an 'X' in the 'Sel' column. Select the PF4 key. LFAM will transfer to LFA2, 'LTACS – TXIX Eligibility' screen.
  - FAMIS application: From the FAMIS screen, type "FAMISPAR plus 00xxxxxxxx (participant's DCN)" and press Enter. FAMISPAR shows if a participant has Medicaid benefits.
- Participant Income:
  - PROD application: From the LFAM screen select the type of assistance to be reviewed by entering an 'X' in the 'Sel' column. Select the PF3 key. LFAM will transfer to the LFA1 'FAMIS Participation Members' screen.
  - FAMIS application: From the FAMISPAR screen, type 'selinc' in the command line, cursor down to the MA line and type in 's' and select the Enter key, to transfer to the screen that displays the income. Move the cursor to the appropriate income 'Sel' line, type an 's' and select the Enter key. This will transfer to the monthly income for each source. If there is income from several sources, they are to be added to determine total income.

- Transfer of Property Penalty:
  - PROD application: View the LTACS Title XIX Inquiry Screen (LXIX) to determine if there is a Transfer of Property Penalty (YES=Transfer of Property Penalty).
- Medicaid Spenddown or Ticket to Work data:
  - PROD application:
    - From the LFAM screen, select the type of assistance to be reviewed by entering an 'X' in the 'Sel' column. Select the PF8 key. LFAM will transfer to the MSPI screen for spenddown and Ticket to Work eligibility information.
    - MPNI screen provides information regarding the amount of the participant's spenddown or Ticket to Work liability amount, the status of the current liability amount, and the last date of Medicaid coverage. When using MPNI, the letters 'AF' must be placed in front of the DCN in order to see coverage.

Special Circumstances

Spenddown (see Appendix 1)

Participants who meet all of the other Medicaid eligibility requirements, but have income in excess of the established monthly income limit to be eligible for Medicaid benefits, are considered spenddown participants. Within the 'HCBS Eligibility' tab, system messages will display to alert the user as to whether or not the participant has met their spenddown liability for the current date.

> **Note**: Medicaid eligibility may not reflect 'real time' information for spenddown participants as it may take up to 72 hours for the latest information to display in the HCBS Web Tool.

New HCBS Referrals for Spenddown Participants

Upon receipt of a referral for a Medicaid spenddown participant who has met their spenddown liability for the current date, DSDS shall:

- Review the eligibility determination message within the HCBS Web Tool and/or DSS Network screens in order to validate the participant is currently in an active period of Medicaid eligibility; and if active,
- Initiate and complete the HCBS process within the HCBS Web Tool; and
- Instruct the participant that during periods of ineligibility, costs incurred for HCBS will be the participant's responsibility.

Upon receipt of a referral for a Medicaid spenddown participant who has not met their spenddown liability for the current date and is ineligible for Home and Community Based (HCB) Medicaid, DSDS shall:

- Be unable to process the PreScreen within the HCBS Web Tool; and
- Refer the participant to FSD for information on Medicaid benefits, and instruct the participant to contact the HCBS Call Center for HCBS eligibility determination when Medicaid benefits are active.

Note: If a spenddown participant appears to have income which meets the requirements for HCB Medicaid determination (including the request for an Aged and Disabled Waiver service), an IM-54A for HCB Medicaid determination shall be forwarded to FSD by DSDS staff (see below and Appendix 1). If approved for HCB Medicaid by FSD, Medicaid will reimburse for HCBS retroactive to the date of HCB Medicaid eligibility.

Reassessment of Existing HCBS Spenddown Participants

At reassessment, a spenddown participant must either have met spenddown liability for the current date **or** have met spenddown liability at least once within the previous three (3) months in order to continue with the reassessment process. DSDS shall:

- Review the eligibility determination message within the HCBS Web Tool and/or DSS Network screens in order to validate the participant is eligible for the HCBS reassessment process; and
- Initiate and complete the HCBS reassessment process within the HCBS Web Tool; or
- Initiate the adverse action process (see Policy 5.00) when spenddown liability has not been met within the last three (3) months. When appropriate, proceed with closing any associated open prior authorizations for services **and** the case (see Policy 10.20).

  Note: At the time of reassessment the record of a spenddown participant shall be reviewed to determine if the participant meets the eligibility requirements for HCB Medicaid. When the spenddown participant appears to be HCB Medicaid eligible the participant shall be processed for HCB Medicaid (see below).

Home and Community Based Medicaid (HCB Medicaid) (see Appendix 1)

Determination of HCB Medicaid eligibility requires inter-agency cooperation between FSD and DSDS. The Home and Community Based Services Referral (IM-54A) shall be used to facilitate communication between the agencies regarding the HCB Medicaid eligibility requirements. The IM-54A, when utilized, shall be uploaded in the HCBS Web Tool. However, the IM-54A is not required to initiate the HCB Medicaid referral process. HCBS Call Center staff shall review all potential participants' eligibility for HCB Medicaid.

Initial Referral for HCB Medicaid

Upon receipt of a referral for an Aged and Disabled Waiver (ADW) service (see Policy 3.00) for a Medicaid spenddown participant who has not met their spenddown liability, but is 63 years of age or older, HCBS Call Center staff shall:

At PreScreen

Review the participant's gross income amount in the DSS Network to determine if the spenddown participant's income is within the HCB income standard (see Appendix 2); and if so, HCBS Call Center staff shall:

- Initiate the HCBS PreScreen process within the HCBS Web Tool by navigating to the Participant Case Summary screen, completing and saving the demographics section and selecting 'Add Case'. Upon selection of 'Add Case', the 'HCB Medicaid Referral' checkbox will become enabled;

- Check the 'HCB Medicaid Referral' box within the 'Eligibility' section which will now enable the 'Add PreScreen' button. Proceed with PreScreen process per Policy 4.05.
  - It is not necessary for HCBS Call Center staff to complete an IM-54A. However, if an IM-54A is received from FSD and the participant meets the preliminary LOC at the PreScreen, HCBS Call Center staff shall upload the IM-54A in the HCBS Web Tool and e-mail the IM-54A to the appropriate DSDS Region.
  - If the participant does not meet the preliminary LOC at the PreScreen, the HCBS Call Center staff shall complete the appropriate portion of the IM-54A and e-mail it to the FSD HCB Processing Center explaining the outcome of the PreScreen of the participant.

At Initial Assessment

- Complete the PCCP process within the HCBS Web Tool and authorization of an ADW service if appropriate criteria are met.
  - If the participant is authorized for an ADW service, DSDS staff shall complete and upload the IM-54A in the HCBS Web Tool and e-mail it to the FSD HCB Processing Center for determination of HCB Medicaid eligibility.
  - If the participant does not meet eligibility for an ADW service at the initial assessment, DSDS field staff shall proceed with the adverse action process (see Policy 5.00). Additionally, if an IM-54A was received from FSD, DSDS field staff shall complete the IM-54A and send it to the FSD HCB Processing Center explaining the outcome of the assessment.

Note: Medicaid spenddown participants who have not met their spenddown liability shall be authorized for services, including an ADW service, pending notification from FSD regarding HCB Medicaid eligibility approval. DSDS staff shall communicate to the HCBS provider(s) that eligibility is pending with FSD.

Current HCBS Participants:

When DSDS or its designee identifies a current HCBS spenddown participant who may now meet HCB Medicaid eligibility, i.e., meets income, age eligibility, and there is an ADW service need documented, staff shall initiate the IM-54A and forward to FSD. At any point during an HCB Medicaid participant's authorization period, if the participant no longer meets eligibility for ADW services, DSDS or its designee shall:

- Initiate the adverse action process (see Policy 5.00).
- Close all prior authorized ADW services; and
- Complete and forward an IM-54A to FSD when ADW services are closed.

Qualified Income Trust (Miller Trust) (see Appendix 1)

Individuals with income in excess of HCB Medicaid requirements may still qualify for Medicaid by diverting a portion of their income into a qualified income trust (i.e., Miller Trust). Miller Trusts are limited to persons needing Medicaid for nursing facility care or for services provided through the ADW.

Similar to the logistical process for HCB Medicaid referrals, eligibility determination of Medicaid benefits through a Miller Trust requires inter-agency cooperation between FSD and DSDS.

Initial Referral for Miller Trust

FSD shall fax the IM-54A to the HCBS Call Center with "Miller Trust" written in the Comments field For FSD Use Only section to facilitate communication between the agencies regarding Medicaid eligibility requirements. Upon receipt of an IM-54A for a Miller Trust referral on an individual who potentially meets the eligibility criteria for an ADW service (see Policy 3.00), HCBS Call Center staff shall:

At PreScreen

- Initiate the HCBS PreScreen process within the HCBS Web Tool by navigating to the Participant Case Summary screen, completing and saving the demographics section and selecting 'Add Case'. Upon selection of 'Add Case', the 'HCB Medicaid Referral' checkbox will become enabled;
- Check the 'HCB Medicaid Referral' box within the 'Eligibility' section which will now enable the 'Add PreScreen' button. Proceed with PreScreen process per Policy 4.05.
  - If the participant meets the preliminary LOC at the PreScreen, the IM-54A received from FSD shall be uploaded in the HCBS Web Tool and e-mailed to the appropriate DSDS Region.
  - If the participant does not meet the preliminary LOC at the PreScreen, HCBS Call Center staff shall complete the appropriate portion of the IM-54A and e-mail it to the location as instructed by FSD, explaining the outcome of the PreScreen of the participant.

At Initial Assessment

- Complete the PCCP process within the HCBS Web Tool and authorization of an ADW service if appropriate criteria are met.
  - If the participant is authorized for an ADW service, DSDS staff shall complete and upload the IM-54A in the HCBS Web Tool and e-mail it to the location as instructed by FSD for determination of Miller Trust Medicaid eligibility.
  - If the participant does not meet eligibility for an ADW service at the initial assessment, DSDS field staff shall proceed with the adverse action process (see Policy 5.00). Additionally, if an IM-54A was received from FSD, DSDS field staff shall complete the IM-54A and e-mail it to the location as instructed by FSD explaining the outcome of the assessment.

Note: Medicaid spenddown participants who have not met their spenddown liability shall be authorized for services, including an ADW service, pending notification from FSD

regarding Miller Trust Medicaid eligibility approval. DSDS staff shall communicate to the HCBS provider(s) that eligibility is pending with FSD.

Division of Assets (Appendix 1)

If a person is living in a nursing facility receiving vendor nursing care or receiving certain types of HCBS, federal law provides a way to protect some of that person's assets for a community spouse. The law also provides for setting aside income, if needed, for a community spouse or dependents. When one spouse from a married couple receives HCBS and the other spouse does not, that spouse is called the "community spouse." A special provision, called "Division of Assets," helps to prevent spousal impoverishment.

Initial Referral Process for Medicaid with a Division of Assets:

In instances where the participant does not potentially qualify for Medicaid benefits without a Division of Assets between the participant and their spouse, FSD must submit an IM-54A to the HCBS Call Center to initiate the referral process.

Upon receipt of the IM-54A for a Division of Assets, HCBS Call Center staff shall:

- Complete a paper PreScreen, as the HCBS Web Tool does not allow an electronic PreScreen to be entered when Medicaid benefits have not been approved; and
- Determine if the participant meets the preliminary nursing facility LOC.
    - If the participant meets the preliminary LOC, the Call Center staff shall e-mail the IM-54A to the appropriate Region to inform of the pending referral.
    - If the participant does not meet the preliminary LOC, the Call Center staff shall initiate the adverse action process (see Policy 5.00) and complete the IM-54A and e-mail it to the FSD HCB Processing Center explaining the outcome of the PreScreen of the participant.

Upon receipt of the paper PreScreen referral, DSDS field staff shall:

- Complete a paper assessment and preliminary PCCP.
    - If LOC is met and the participant is eligible for an ADW service, DSDS field staff shall e-mail the IM-54A with information from the assessment to the FSD HCB Processing Center. If eligibility is met, FSD will proceed with a Division of Assets. Upon notification of approved Medicaid eligibility, DSDS field staff shall complete the electronic InterRAI HC and PCCP authorization in the HCBS Web Tool.
    - If eligibility for an ADW service is not met upon the assessment, DSDS field staff shall complete the adverse action process (see Policy 5.00) and will complete the IM-54A with the outcome of the assessment and route to the FSD HCB Processing Center.

Specified Low Income Medicare Beneficiary 2 (SLMB2)

QMB, SLMB1, and SLMB2 are programs which provide assistance with Medicare premiums, co-insurance, and deductibles for qualifying individuals. QMB and SLMB1 beneficiaries may also be eligible for Medicaid benefits. SLMB2 beneficiaries may be Medicaid eligible if requirements are met, however, FSD requires the participant to choose Medicaid or SLMB2 coverage.

Initial Referral Process for Participants with SLMB2 Benefits

In instances where the participant has SLMB2 benefits, but desires to have HCB Medicaid and meets the eligibility requirements for HCB Medicaid, FSD must submit an IM-54A to the HCBS Call Center to initiate the referral process.

Upon receipt of the IM-54A, HCBS Call Center staff shall:

- Complete a paper PreScreen, as the HCBS Web Tool does not allow an electronic PreScreen to be entered when Medicaid benefits have not been approved; and
- Determine if the participant meets the preliminary nursing facility LOC.
  - If the participant meets the preliminary LOC, the Call Center staff shall e-mail the IM-54A and PreScreen results to the appropriate Region to inform of the pending referral.
  - If the participant does not meet the preliminary LOC, the Call Center staff shall initiate the adverse action process (see policy 5.00) and will complete the IM-54A and e-mail it to the FSD HCB Processing Center explaining the outcome of the PreScreen of the participant.

Upon receipt of the paper PreScreen referral, DSDS field staff shall:

- Complete a paper assessment and preliminary PCCP.
  - If LOC is met and a need for HCBS is identified upon the assessment, DSDS field staff shall complete the IM-54A with information from the assessment and e-mail it to the FSD HCB Processing Center. If eligibility is met, FSD will proceed with changing coverage to HCB Medicaid from SLMB2 if desired (the participant is only eligible for one program). Upon notification of approved Medicaid eligibility, DSDS field staff shall complete the electronic InterRAI HC and PCCP authorization in the HCBS Web Tool.
  - If LOC is not met upon the assessment, DSDS field staff shall initiate the adverse action process (see policy 5.00) and will complete the IM-54A with information from the assessment and e-mail it to the FSD HCB Processing Center.

Note: Whether an electronic or paper PreScreen is received by field staff, there shall be no ocessing the initial referral. Each referral will be prioritized appropriately.

Note: If FSD communicates a denial of HCB Medicaid benefits through the completion of the IM-54A, DSDS staff shall proceed with the adverse action process (see Policy 5.00).

Blind Pension ME code '02'

Participants with an ME code of '02', Blind Pension, have restricted medical assistance benefits through state only funds and are **not** eligible for services funded through the ADW, the Independent Living Waiver (ILW), or the Adult Day Care Waiver (ADCW). ME code '02' participants **are** eligible for State Plan services (see Policy 3.00). The HCBS Web Tool will provide a warning message within the 'HCBS Eligibility' tab to alert the user the participant is only eligible for State Plan HCBS and will prevent the authorization of any waiver services.

When a current HCBS participant's Medicaid eligibility changes to ME code '02' DSDS shall:

- Initiate the adverse action process (see Policy 5.00); and
- Close all prior authorized ADW, ILW, or ADCW services.

Ticket to Work Health Assurance (TWHA) - Premium ME code '85' (Appendix 1)

The TWHA program provides Medicaid coverage, including HCBS, for persons with disabilities age 16 through 64 who are employed.

New HCBS Referrals for TWHA

TWHA participants have the responsibility to pay a premium in order to access Medicaid benefits. The 'HCBS Eligibility Determination' Tab will display a message based on whether or not the TWHA participant has paid their premium, either 'Paid' or 'Not Paid'. DSDS may also utilize the MSPI screen within the DSS Network to validate that the premium has been paid. When participants have paid their premium and are therefore eligible for Medicaid benefits as TWHA-premium ME code '85', DSDS shall:

- Initiate and complete the HCBS process within the HCBS Web Tool; and
- Instruct the participant that during periods of ineligibility, due to non-payment of the premium, costs for HCBS will be the participant's responsibility.

Reassessment of Existing TWHA Participants

At reassessment, a TWHA participant must either have paid their premium for the current month **or** have paid their premium at least once within the previous three (3) months in order to continue with the reassessment process. DSDS or its designee shall:

- Review the eligibility determination message within the HCBS Web Tool and MSPI to determine if the HCBS reassessment process should be completed; or
- Initiate the adverse action process when the TWHA premium has not been paid within the last three (3) months, (see Policy 5.00) and proceed with closing the case and any associated open Prior Authorizations in the HCBS Web Tool (see Policy 10.20).

Transfer of Property Penalty

Participants with a transfer of property penalty have limited Medicaid benefits and are not entitled to ADW 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, ILW, or 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 Miller Trust does not constitute a Transfer of Property Penalty.

- Staff shall review the LXIX screen in the DSS Network to determine if the participant has a transfer of property penalty.

  Note: Transfer of property data within the HCBS Web Tool on the 'HCBS Eligibility' tab is not functional.