BENEFICIARY ELIGIBILITY

The Bureau of Health Services Financing (BHSF), within the Louisiana Department of Health (LDH), is responsible for determining Medicaid eligibility.

Individuals may apply for Medicaid by mail, online, in person, or through a responsible authorized representative at any Medicaid office or application center.

Individuals certified for Medicaid are classified into various eligibility categories or groups based on specified criteria. These criteria may affect provider reimbursement.

The regulations contained in Title 42 of the Code of Federal Regulations define the groups of individuals and services a state must cover to qualify for federal matching payments. States define their programs to meet these federal requirements and coverage of groups and benefits, specified under federal law.

Categorically Needy

Beneficiaries classified as categorically needy must meet all requirements, including income and resource requirements. Payment for all covered services or equipment furnished to these beneficiaries and billed to BHSF shall be considered payment in full; however, beneficiaries are responsible for pharmacy co-payments.

Beneficiaries determined to be categorically needy include:

1. Families who meet low-income families with children (LIFC) eligibility requirements;

2. Pregnant women with family income at or below 200 percent of the Federal poverty level;

3. Children under age 19 with family income up to 250 percent of the Federal poverty level;

4. Caregivers (relatives or legal guardians who care for children under the age of 18, or 19 if still in high school);

5. Supplemental Security Income (SSI) beneficiaries; and

6. Individuals and couples who are living in medical institutions and who have a monthly income up to 300 percent of the SSI income standard (Federal benefit rate).

Medically Needy

Medically needy is an optional program; however, states that elect to include this program are required to include certain children under age 18 and pregnant women who would be eligible as categorically needy, if not for their income and resources.

Beneficiaries may qualify as regular **medically needy** or **spend-down medically needy**.

Regular medically needy beneficiaries are those individuals or families who meet all LIFC related categorical requirements and whose income is within the Medically Needy Income Eligibility Standard (MNIES).

Spend-down medically needy beneficiaries are those individuals or families who meet all LIFC or SSI related categorical requirements **and** whose resources fall within the medically needy resource limits, but whose income has been spent down to the MNIES.

Medically needy beneficiaries are identified on the Medicaid Eligibility Verification System (MEVS) and Recipient Eligibility Verification System (REVS). MEVS and REVS denote the appropriate eligibility information based on the provider type of the inquiring provider.

Service restrictions apply to medically needy benefits and eligibility for service coverage should be verified.

The following services are not covered in the Medically Needy program:

1. Adult dental services or dentures;
2. Mental health clinic services;
3. Home and community based waiver services;
4. Home health (nurse aide and physical therapy); and
5. Case management services.

Information detailing the other beneficiary categories and eligibility groups may be obtained by accessing the *Medicaid Eligibility Manual* on the LDH website.

Providers should refer beneficiaries with questions regarding eligibility to the Louisiana Medicaid and LaCHIP Assistance Line. (Refer to Appendix B for contact information).

Retroactive Eligibility

Beneficiaries may be eligible for benefits for the three months prior to the date of their Medicaid application provided they meet the eligibility criteria.

When a beneficiary has paid a provider for a service for which they would be entitled to have payment made under Medicaid, the provider may opt to refund the payment to the beneficiary and bill Medicaid for the service. The beneficiary must furnish a valid Medicaid identification card for the dates of services provided during the timely filing period. If a provider chooses not to refund the payment to the beneficiary, the beneficiary should be directed to the MMIS Retroactive Reimbursement Unit to request a refund (Refer to Appendix B for contact information).

Medicaid Verification

Medicaid Identification Cards

A plastic Healthy Louisiana identification card, with a unique identifying number, is issued to each eligible beneficiary by LDH.

These permanent identification cards contain a card control number (CCN) that is used by the provider to verify Medicaid eligibility. Eligibility information for that beneficiary, including third party liability and any restrictions, may be obtained by accessing information through MEVS or calling REVS.

Some types of Medicaid eligibility, such as Illegal/Ineligible Aliens (eligible for emergency services only) do not receive permanent identification cards. Their verification of eligibility is contained on the Notice of Eligibility Decision issued by the local Medicaid office. Providers should call the general information hotline (refer to Appendix B for contact information) to verify presumptive eligibility (PE).

Medicaid Eligibility Verification System

MEVS is an electronic system used to verify Medicaid beneficiary eligibility and third party liability (TPL). This information is accessed through personal computer (PC) software, an "eligibility card device", or computer terminal. MEVS is available seven days per week, 24 hours per day, except for occasional short maintenance periods.

Providers may also access MEVS by contracting with telecommunications vendors ("switch vendors") who will provide a magnetic card reader, PC software, or a computer terminal necessary for system access.

MEVS Access Data

Any two of the following identifying information may be used to access the system and receive eligibility information from MEVS:

1. CCN and card issue date;
2. Beneficiary name;
3. Beneficiary identification (ID) number;
4. Date of birth; and
5. Social security number (SSN).

Beneficiary Eligibility Verification System

REVS is a telephonic system used to verify Medicaid beneficiary eligibility. It is available seven days per week, 24 hours per day, except for occasional short maintenance periods. REVS provides basic eligibility, service limits and restrictions, TPL, and program eligibility information. It is accessible through any touch-tone telephone equipment. (Refer to Appendix B for contact information).

REVS Access Data

Providers may access beneficiary eligibility by using the following identifying information:

1. CCN and date of birth;
2. CCN and SSN;
3. Medicaid ID number (valid during the last 12 months) and date of birth;
4. Medicaid ID number (valid during the last 12 months) and SSN; and
5. SSN and date of birth.

MEVS and REVS Reminders

Failure to comply with these procedures may result in problems with MEVS and REVS:

1. A valid eight-digit date of birth (mm/dd/yyyy) must be entered when using REVS or MEVS.

2. Eight-digit dates (mm/dd/yyyy) must be used when entering any dates through either system.

3. Where applicable, providers should listen to the menu and press the appropriate keys to obtain Lock-In information through REVS.

4. When using a beneficiary's 13-digit Medicaid ID number, remember that both systems carry only beneficiary numbers that are valid for the last 12 months. If you are entering an old number (valid prior to the last 12 months), you will receive a response that indicates the beneficiary is not on file.

5. When using a 13-digit Medicaid ID number or a 16-digit CCN for your inquiry into either system, you will receive the most current, valid 13-digit Medicaid ID number as part of the eligibility response.

6. Claims must be filed with the 13-digit Medicaid ID number.

Every effort is made to ensure that all beneficiaries' dates of birth are accurate on the Medicaid file. A REVS or MEVS reply of "beneficiary not on file" may be the result of an incorrect beneficiary date of birth on Medicaid files. In this situation, the provider should refer the beneficiary to their parish office or have the beneficiary call the General Hotline (Refer to Appendix B for contact information).

NOTE: **Eligibility is date specific.** It is important to confirm eligibility prior to providing the service. Providers who do not confirm eligibility risk the denial of reimbursement for services provided.