37.3 MEDICAID RECIPIENT ELIGIBILITY

Overview

Introduction

This Section describes who can qualify for Medicaid benefits in Louisiana and the different eligibility groups and limitations.

Additionally, this Section informs providers of the processes used to verify Medicaid eligibility.

Note: Providers should refer to Chapter 2 of the Louisiana Medicaid Program Provider Manual for detailed information about recipient eligibility.

In This Section

This Section contains:

37.3.1 ELIGIBILITY DETERMINATION

Eligibility Requirements

To qualify for Medicaid, an individual must meet specific eligibility requirements, such as income, assets, age, citizenship or resident alien status, and Louisiana residency. The individual must have a social security number or proof of having applied for one.

Who Determines Eligibility

Eligibility for Medicaid is determined by the Bureau of Health Services Financing (BHSF) Medicaid Program and by the federal Social Security Administration (SSA) for certain categories of elderly and disabled individuals.

Eligibility Determined by SSA

The SSA determines eligibility for Supplemental Security Income (SSI). SSI recipients are automatically eligible for Louisiana Medicaid.

Eligibility Periods

Periods of Medicaid Coverage are not the same for all Medicaid eligibility programs. Depending on the Medicaid program, the recipient's eligibility may begin either on the first day of the month of application or on a specific day within the month and end before the last day of the month. Medicaid eligibility may be approved retroactively for up to three months prior to the date of application with some exceptions.

Medicaid coverage will continue as long as a recipient meets all of the requirements for eligibility. A provider must verify a recipient's eligibility for the date of service prior to rendering the service.

37.3.2 CLASSIFICATIONS OF ELIGIBLE RECIPIENTS

There are two main classifications for eligible recipients of Medicaid of Louisiana:

Categorically Needy

Recipients classified as Categorically Needy must meet all requirements, including the financial income standard, and resource requirements of one of the cash assistance programs. The existing categorical programs are the Supplemental Security Income administered programs that provide assistance for the Aged, Blind or Disabled and the Low Income Families with Children program, which is based on the requirements for the Temporary Aid to Needy Families program administered by the Department of Social Services (DSS):

Aged

Provides health assistance to individuals who are over 65 years of age and who meet the income and resource requirements of the program.

Blind

Provides health assistance to individuals who are determined legally blind according to the SSI criteria and who meet the income and resource requirements of the program.

Disabled

Provides health assistance to individuals who are determined to meet the Social Security Disability criteria and who meet the income and resource requirements of the program.

TANF

(Temporary Aid to Needy Families) provides health assistance to children and families who meet the income, resource and other eligibility criteria for the TANF program administered by DSS. This is the program that replaced the Aid to Families with Dependent Children program in the Welfare Reform legislation.

LIFC

(Low Income Families with Children) provides health assistance to children (under age 19) and pregnant women who meet income and non-financial eligibility criteria. The requirements for this program are based on the requirements for the Temporary Aid to Needy Families program administered by DSS.

Recipients are responsible for a co-payment for prescription drugs. However, children up to the age of twenty-one; pregnant women; institutionalized individuals; emergency services; and family planning services are exempt from co-payments.

Payment for all covered services or equipment billed to Medicaid shall be considered **payment in full**.

Medically Needy

Medically Needy recipients must meet all of the requirements of the cash programs administered by SSI or the TANF program administered by DSS except income. These individuals have more income than is allowable under the cash programs, but qualify under the Medically Needy Program income standard, because of their need for medical services. Medically Needy recipients may be either Regular Medically Needy or Spend-Down Medically Needy.

Regular Medically Needy

Regular Medically Needy recipients are those individuals or families who meet all LIFC (Low-Income Families with Children) related categorical requirements and whose income is within the Medically Needy Income Eligibility Standard (MNIES).

With the exception of co-payments for prescription drugs, no payment can be accepted from a Regular Medically Needy recipient for covered services.

Spend Down Medically Needy

Spend-down applicants may qualify for the Medically Needy Program on the basis that countable income has been spent or obligated to pay unpaid medical expenses. Spend-down medically needy eligibility begins on the exact date that medical expenses are incurred by these recipients, and countable income is reduced to the Medically Needy Income Standard allowing them to meet "spend-down" criteria. These recipients are responsible for a co-payment for some expenses.

Any provider who has medical bills from the exact date of the recipient's spend-down will receive a **Spend-down Medically Needy Notice (Form 110-MNP)** from Medicaid. This form will notify the provider of the co-payment amount due by the recipient and the amount to be billed to Medicaid. *The provider must attach this form to the universal claim form and submit the claim manually to the fiscal intermediary for processing.* The provider cannot bill the recipient for any amount over the amount specified on the Form 110-MNP under recipient liability. If services were provided on the date of spend-down but do not appear on the 110-MNP form, the provider should contact the local Medicaid office that issued the form to get a corrected form.

Medically Needy Recipients are identified on the MEVS and REVS system. MEVS and REVS denote the appropriate eligibility information based on the provider type of the inquiring provider. RECIPIENTS ELIGIBLE THROUGH PROGRAMS OTHER THAN THE MEDICALLY NEEDY PROGRAM ARE NOT AFFECTED.

Recipients with questions should contact Medicaid's Eligibility Section at 888- 342-6207. Providers with inquiries should call the fiscal intermediary Provider Relations at 800-473-2783 or 225-924-5040.

Service restrictions apply to Medically Needy benefits and eligibility for service coverage should be verified.

37.3.3 ELIGIBILITY GROUPS

CHAMP (Child Health and Maternity Program) provides health assistance to children (under age 19) and pregnant women who meet income and non-financial eligibility criteria.

Transitional Assistance Provides up to 12 months continued Medicaid coverage for families who lost Medicaid eligibility due to an increase in earnings or due to the loss of earned income deductions.

LaCHIP (Louisiana Children's Health Insurance Program) provides health assistance to targeted low-income child (ren):

- Under the age of 19;
- Not eligible for Medicaid under any other eligibility group;
- Whose family income meets the specified cut off level; and
- Does not have other credible health insurance.

LaCHIP Phase IV The Phase IV LaCHIP Program is an expansion of the State Children's Health Insurance program (SCHIP). This program provides prenatal care services, from conception to birth, for low income uninsured mothers who are not otherwise eligible for Medicaid, including CHAMP PW benefits. Phase IV LaCHIP expands coverage to non-citizen pregnant women who are not qualified for other Medicaid programs due to citizenship status only.

LaChip Affordable Plan LaCHIP Affordable Plan is a LaCHIP health insurance program for uninsured children in moderate income families whose income is too much to qualify for regular LaCHIP but whose gross income is below 250 percent of the Federal Poverty Level (FPL). The regular LaCHIP only covers uninsured children in families with countable income up to 200 percent of the FPL.

B/CC	(Breast and Cervical Cancer) provides full Medicaid coverage to uninsured women under age 65 who are identified through the Centers of Disease Control and Prevention's national Breast and Cervical Early Detection Program and in need of treatment for cervical and/or breast cancer, including pre-cancerous conditions.
LTC	(Long Term Care) provides Medicaid coverage to elderly and/or disabled individuals who are income and resource eligible and who need medical certification for services provided in a long term care facility or through home and community based services.
DAC	(Disabled Adult Children) provides Medicaid coverage to individuals over age 18, who became blind or disabled before age 22, and lost SSI eligibility on or after July 1, 1987, as the result of entitlement to or increase in RSDI.
DW/W	(Disabled Widows/Widowers) provides Medicaid coverage to widows/widowers with disabilities who would be eligible for SSI had there been no elimination of the reduction factor in 1984 and no subsequent COLA's
EW/W	(Early Widows/Widowers) provides Medicaid coverage to individuals who lose SSI eligibility because of the receipt of RSDI early widow/widower's benefits.
Pickle	Protects Medicaid coverage for two different groups of aged, blind, or disabled individuals who become ineligible for SSI or MSS as the result of a co st of living adjustment to RSDI benefits, or any other reason.
SGA Disabled W/W/DS	(Disabled widows/widowers and disabled surviving divorced spouses unable to perform any substantial gainful activity) protects Medicaid coverage for widow(er)'s who become ineligible for SSI due to the receipt of SSA Disabled Widow(er)'s Benefits so long as; they were receiving SSI for the month prior to the month they began receiving RSDI, and they would continue to be eligible for SSI if the amount of the RSDI benefits were not counted as income, and they are not entitled to Part A Medicare.
Section 4913 Children	Provides for the continuation of Medicaid coverage for children with disabilities who lost SSI benefits because of the change in the definition of childhood disability. They are eligible if they received SSI benefits as of August 22, 1996, meet all other SSI eligibility factors, including income and resources, and meet the "pre 8/22/96" definition of childhood disability.
TB	(Tuberculosis) infected individuals not eligible for the full range of Medicaid services. Coverage is restricted to outpatient medical services directly related to diagnosis, confirmation and treatment of Tuberculosis.

Emergency Services for Aliens

These individuals must meet criteria for one of the other eligibility groups and are certified only for limited periods of eligibility via Form 18-EMS. Their days of eligibility only cover dates of service on which emergency (life threatening) services were rendered. Once a person's eligibility ceases, he/she must re-apply if coverage for new emergency services is needed.

Presumptive Eligibility

Pregnant women may have "Presumptive Eligibility (PE)" determined by a "qualified provider" such as some state hospitals, public health units, rural health clinics or Child and Maternal Health grantees. Presumptive eligibility begins on the date the qualified provider determines the pregnant woman is eligible. If the recipient does not file an application for Medicaid, eligibility ends the last day of the following month.

If a Medicaid application is filed, the woman will remain presumptively eligible until the eligibility on her application is determined. During this period, the "presumptively eligible" pregnant women will be eligible for ambulatory (outpatient) prenatal care including non-emergency transportation. Coverage may expire at any time if eligibility requirements are not met. MEVS and REVS eligibility verification responses will alert providers that the recipient may be eligible for outpatient ambulatory services only and that providers must inquire to verify eligibility. **Verification should be made by calling 800-834-3333.**

Newborn Eligibility

Provides health assistance to a child born to a woman determined eligible for Medicaid benefits in any category (other than Presumptive Eligibility) on the date the child is born until its first birthday as long as the newborn resides in the home of the mother. If the mother is not eligible for Medicaid at the time of the child's birth then an application would have to be filed and the child would have to be found eligible for Medicaid under one of the existing Medicaid programs *for children.*

Take Charge

Take Charge is a Section 1115 Demonstration Waiver to provide family planning services for women between the ages of 19-44 who have income up to 200% of the Federal Poverty Level. The waiver program, named "Take Charge" has a specified benefit package. Services will include yearly physical exams, laboratory tests, contraceptive counseling, medications and supplies (such as birth control pills, patches, injections, intrauterine devices, diaphragms, etc.). Voluntary sterilization procedures are also included. Services may be provided by any enrolled Medicaid provider(s) whose scope of practice permits the delivery of the services covered by the waiver program.

Program of All Inclusive Care for the Elderly (PACE)

PACE programs coordinate and provide all needed preventive, primary, acute and long term care services so that older individuals can continue living in the community. PACE programs generally consist of an adult day health center where primary care physician services and other services are also available.

Pharmacy claims of PACE participants will be denied by Medicaid as these services are included in the reimbursement to the PACE provider. PACE providers will be responsible for reimbursing prescription services.

Full Benefit Dual Eligibles (Medicare/Medicaid)

The following describes the various categories of individuals who, collectively, are known as full benefit dual eligibles. Medicare has two basic coverages: Part A, which pays for hospitalization costs; and Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services which may include eligible Part B drugs. Effective January 2006, the Medicare Modernization Act provides for an outpatient drug benefit (Part D). Full benefit dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and Part D as well as eligible for some form of Medicaid benefit.

For those individuals **with** Medicaid benefits, Louisiana Medicaid will reimburse providers the coinsurance and/or deductible amounts submitted for Medicare Part B drugs that have been adjudicated by Medicare.

The following are full benefit dual eligible classifications as defined by Medicare and Medicaid.

Note: Refer to Section 37.7 Medicare Crossover Policy for detailed information.

QMB Plus

Qualified Medicare Beneficiaries (QMBs) with full Medicaid - These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance, and provides full Medicaid benefits.

SLMB Plus

Specified Low-Income Medicare Beneficiaries (SLMBs) with full Medicaid – These individuals are entitled to Medicare Part A, have income of 100-120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits.

Non QMB, SLMB, QDWI, or QI

These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, Qualified Disabled and Working Individual (QDWI) or Qualified Individual (QI). Typically, these individuals need to spend down to qualify for Medicaid or fall into a special Medicaid eligibility group. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but only to the extent that the Medicaid rate exceeds any Medicare payment for services covered by both Medicare and Medicaid. Payment by Medicaid of Medicare Part B premiums is a State option.

Medicare Premium, Deductible and Coinsurance Eligible Only

The following qualify only for Medicaid payments of Medicare premiums, deductibles and coinsurance.

QMB Only

QMBs without other Medicaid (QMB Only) These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare Providers.

For those individuals who are QMB only, Medicaid will pay a crossover claim only if the service is covered by Medicaid, otherwise the claim will deny as non-covered.

Medicare Premium Coverage Only

The following qualify only for Medicaid payments of Medicare premiums.

SLMB Only

SLMBs without other Medicaid (SLMB Only) – These individuals are entitled to Medicare Part A, have income of 100-120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

QDWIs

Qualified Disabled and Working Individuals (QDWIs) – These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

QIs

Qualified Individuals (QIs) – These individuals are entitled to Medicare Part A, have income of 120%-135% FPL and resources that do not exceed twice the limit for SSI eligibility and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

37.3.4 PROOF OF ELIGIBILITY

Eligibility information for a recipient, including third party liability, primary care providers and any restrictions, including lock-in, may be obtained by accessing information through the Medicaid Eligibility Verification System (MEVS), or telephoning the Recipient Verification System (REVS) toll-free at 800-776-6323 or the local number at 225-216-7387.

Medicaid Eligibility Verification System (MEVS)

MEVS is an electronic system used to verify Medicaid recipient eligibility information and can be accessed through www.lamedicaid.com. This system is available seven (7) days per week, 24 hours per day except for occasional short maintenance periods.

Note: Refer to Section 37.22 Louisiana Medicaid Website for detailed information.

Recipient Eligibility Verification System (REVS)

REVS is a telephonic system used to verify Medicaid recipient eligibility. It is available seven (7) days a week, 24 hours per day except for short maintenance periods. This system is accessible through touch-tone telephone equipment using Molina toll-free telephone number at 800-776-6323 or 225-216-7387.

Medicaid Identification

A plastic Health Network of Louisiana Eligibility card, with a unique identifying Card number, is issued to each eligible recipient by the Department of Health and Hospitals (DHH).

Take Charge program enrollees receive a pink identification card similar to a regular Medicaid card in appearance.

Note: Refer to Chapter 2 Generic Eligibility of the Louisiana Medicaid Program Provider Manual for detailed information and an example of a Medicaid identification card.

Card Control Number

The sixteen-digit number on the front of the Medicaid identification card is the card control number and is used to bill for pharmacy services.

Card Not Proof of Eligibility

Possession of a Medicaid identification card does not mean a recipient is eligible for Medicaid Services. Verification must be obtained through MEVS or REVS.

Also, some types of Medicaid eligibility, such as Presumptively Eligible Pregnant Women and Undocumented Aliens (eligible for emergency services only) do not receive plastic Medicaid cards. Their verification of eligibility is contained on the Notice of Eligibility Decision issued by the local Medicaid office.

For Presumptive Eligibility recipients, call toll-free 800-776-6323 to verify eligibility or view the notice of issuance of Eligibility sent from the Bureau notifying them of their eligibility. Providers may call REVS at 800-776-6323 to verify eligibility.

Recipient Has Lost Identification Card

A replacement Medicaid card can be ordered by calling 800-834-3333 or by calling the LaCHIP hotline at 877-242-2447. Choose the "Replace Medicaid Card" option and provide the information required to obtain a replacement Medicaid card through the automated system.

If the recipient is not in possession of his or her identification card, the provider can still verify eligibility and, if the recipient is eligible, provide services.

37.3.5 EPSDT RECIPIENTS

All eligible children under age 21 are covered in the Early Periodic Screening Diagnosis Treatment Program (EPSDT).
Note: Refer to Chapter 20 EPSDT of the Louisiana Medicaid Program Provider Manual for additional information.

37.3.6 LOCK-IN PROGRAM

Medicaid has developed a program to educate recipients who may be misusing program benefits and to ensure that program funds are used to provide optimum health services for recipients. Recipients who misuse or over-utilize pharmacy and physician benefits may be restricted to the use of one pharmacy and one physician, or one pharmacy provider (for pharmacy only Lock-In).

Note: Refer to Section 37.17 Lock-In for detailed information.

37.3.7 THIRD PARTY LIABILITY

Federal regulations and applicable state laws require that third-party resources are used before Medicaid is billed. ***Third party*** refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, that can be applied toward the Medicaid recipient's medical and health expenses.

Providers are able to coordinate benefits or "split-bill" pharmacy claims through the Medicaid Point of Sale system. Providers must bill recipients' primary insurance companies before billing Medicaid. Medicaid will reimburse providers for the recipient's responsibility of coinsurance, co-payments and/or deductibles with other insurance companies up to the maximum Medicaid allowed amount.

Note: Refer to Section 37.8 Third Party Liability/Coordination of Benefits for further explanation of this process.