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SECTION G - MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
SSI RETRO AND INTERIM MONTHS DETERMINATIONS

A. GROUP DESCRIPTION

Federal regulations mandate that eligibility for medical assistance begin with the third month prior to the month of application for SSI for all applicants who:

1. Have received services covered by Title XIX during any of the 3 month period; and

2. Meet all eligibility criteria in the retroactive month(s) when the service was provided.

Eligibility for retroactive Medicaid cannot be established unless or until an application for SSI is filed. (The month of application for SSI or MAO locks in the retroactive period.) The applicant may be eligible for Medicaid in the retroactive period regardless of whether the application for SSI is approved or denied. In addition, an application for retroactive benefits may be filed on behalf of a deceased individual provided an application for SSI has been filed.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) requires that SSI payments begin as of the first day of the month following the date application is filed, or if later, the date the individual first meets all eligibility factors. If the individual meets the eligibility requirements for any MAO coverage group during the interim period of time between the date of application for SSI and the month the SSI payment begins, Medicaid coverage must be provided to the individual for this period of time. A separate application is required for coverage of this interim period through a Medicaid Regional Office. This separate application may be filed in conjunction with an application for SSI retroactive benefits or as a separate application.

B. ELIGIBILITY CRITERIA

Eligibility for medical assistance must be established separately for each month of the retroactive and interim month(s) period. An individual may be eligible in one or more months of the retroactive and/or interim period. The individual will be certified for only those prior months in which eligibility can be established. All technical and financial eligibility criteria must be met for each month.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
SSI RETRO AND INTERIM MONTHS DETERMINATIONS

The application for SSI determines the 3 month retroactive time period consideration for coverage, i.e., the 3 months prior to the month the SSI application is filed and the interim period before the SSI payment started. However, the applicant can be considered for coverage under any available coverage group that he/she may qualify for when considering all eligibility factors. For example, if it is to the SSI retro applicant's advantage to use liberalized resource policy available through the Poverty Level Aged & Disabled (PLAD) Coverage Group and the applicant meets all eligibility criteria for PLAD coverage, then it is permissible to place the applicant in PLAD coverage group for the SSI retroactive and interim period.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

A. GENERAL DESCRIPTION

The following coverage groups are limited to individuals who once qualified for SSI and SSI-related Medicaid but who lost SSI eligibility either due to title II (Social Security) benefits and/or cost of living adjustments.

To preserve Medicaid coverage for certain groups of individuals who lose SSI payments, Congress enacted special Medicaid continuation provisions. These provisions require State Medicaid agencies to continue to consider specified groups of former SSI recipients as SSI recipients for Medicaid purposes, as long as they would otherwise be eligible for SSI payments. In addition, Medicaid is required to determine if the individual would be eligible for Medicaid under any other group.

An applicant for any of the following coverage groups must meet all SSI eligibility criteria. These groups are entitled to specific income disregards; however, countable income and resources can only be evaluated using SSI need standards and resource policy/limits. If evaluating eligibility under any other coverage group other than the ones cited below, the income disregards specific to the former SSI group do not apply.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

B. HR-1 GROUP

This group of eligibles is referred to as HR-1 because this is the designation of the House of Representatives bill which amended the Social Security Act. This bill required that all persons who were eligible for and receiving Medicaid in August, 1972, and were entitled to Social Security benefits as of that month, must be certified for Medicaid if the only reason for their current ineligibility is the 20% increase made in the Social Security checks for September, 1972.

This does not mean that the 20% increase in SSA benefits received in August, 1972, terminated the client's Medicaid eligibility. It only means that the 20% increase received in September, 1972 will be disregarded in order to determine current eligibility for Medicaid, provided the client is determined to be in the HR-1 group.

1. Eligibility Criteria

To be eligible for HR-1 Medicaid benefits, an individual must meet all three of the following conditions:

- Have been eligible for and receiving Medicaid benefits in the month of August, 1972.
- Have received RSDI benefits for the month of August, 1972. The benefits may have been awarded retroactively.
- Must be eligible for Medicaid using current SSI eligibility requirements when the 1972 20% increase in Social Security benefits is disregarded.

2. Restrictions

The only individuals who can be considered for Medicaid under the HR-1 coverage group are the ones who meet the criteria outlined above. If a couple applies under the HR-1 provision and only one member of the couple is eligible for and entitled to the HR-1 disregard, it is not possible to bring the ineligible spouse into eligibility even though the spouse may be aged, blind, or disabled.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
FORMER SSI RECIPIENTS

No individual or couple can remain eligible or obtain eligibility for Medicaid as a HR-1 recipient if the individual's or couple's income, including the disregarded 1972 20% increase in Social Security, is less than the current SSI Federal Benefit Rate (FBR) appropriate for the case. Persons with total income less than the appropriate FBR are potentially eligible for SSI and should be advised to apply for SSI. Eligibility for Medicaid as a MAO recipient is precluded for these individual's because they do not belong to any MAO coverage group.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

C. COST-OF-LIVING (COL) ELIGIBLES

Section 503 of P.L. 94-566 (the Pickle Amendment) protects categorical Medicaid eligibility for certain recipients of title II Social Security benefits who have lost eligibility for SSI lost eligibility for SSI benefits. This group of eligibles is limited to all current title II recipients who after April, 1977 were entitled to and received both title II and SSI benefits and who lost SSI eligibility. Medicaid eligibility can be established if the individual would still be eligible for SSI if the title II cost-of-living increase(s) which the individual received since the individual was last eligible for and received SSI and title II concurrently were deducted from income. The reason for loss of SSI benefits is not a factor in determining whether an individual is entitled to Medicaid coverage as COL recipient.

1. Eligibility Criteria

To be eligible under the COL coverage group, the individual must meet all of the following criteria:

- The individual must be currently eligible for title II (RSDI) benefits;
- The individual must have been simultaneously eligible for and received both title II and SSI benefits at some time since April, 1977;
- The individual must have lost SSI eligibility since April, 1977;
- The individual must be currently eligible for SSI (on all factors) after deducting from countable income the title II cost-of-living increase(s) received since the last month of simultaneous eligibility for and receipt of SSI.

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2. Restrictions

The only individuals who may be considered eligible for COL Medicaid coverage by virtue of applying the COL disregard are the ones who meet the criteria outlined above. If an eligible couple applies and both members of the couple received SSI and title II and were terminated from SSI, then eligibility may be determined for both individuals as an eligible couple. If a couple applies and only one member of the couple meets the criteria outlined above, it is not possible to determine eligibility for the ineligible spouse as a COL even though the ineligible spouse may be aged, blind or disabled. Although the ineligible spouse cannot be determined eligible as a COL, the title II cost of living increase(s) received by the ineligible spouse since the eligible spouse was last eligible for and received SSI will also be disregarded in the budgeting (deeming) process. The same is true of a parent or parents whose title II income is deemed to an eligible child, i.e., the parent(s) title II cost of living increases are disregarded beginning with the date the child was terminated from SSI.

No individual or couple can remain eligible or obtain eligibility for Medicaid as a COL recipient if the individual's or couple's income, including the disregarded cost-of-living amount(s) of Social Security, is less than the current SSI Federal Benefit Rate (FBR) appropriate for the case. Persons with total income less than the appropriate FBR are potentially eligible for SSI and should be advised to apply for SSI. Eligibility for Medicaid as a MAO recipient is precluded for these individuals because they do not belong to any MAO coverage group.

3. Annual Review of Former SSI Recipients

As a result of a federal court case known as Lynch v. Rank, States are required to notify SSI recipients who were terminated from SSI for the previous 3 years about their possible Medicaid eligibility as a COL eligible. SSA provides tapes each year that identify SSI terminations for the previous 3 years and a notice is issued to each living resident of Mississippi identified on the tapes. The individual is informed of the possibility of Medicaid coverage if all COL criteria is met.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

D. COBRA WIDOW(ER)S

In 1983 Congress amended title II and eliminated the "Additional Reduction Factor" for widow(er)s younger than age 60. This increased title II benefits for some widow(er)s causing SSI ineligibility. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended the Social Security Act to restore Medicaid eligibility for these widow(er)s.

The Social Security Administration identified the affected widow(er)s in Mississippi and the affected individuals were notified to apply. This coverage group is limited to the individuals identified by SSA. The deadline for filing for Medicaid existed between July 1, 1987 through June 30, 1988. No new eligibles are possible under this coverage group.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

E. DISABLED ADULT CHILDREN (DAC'S)

Section 6 of P.L. 99-654, The Employment Opportunities for Disabled Americans Act, specifies that effective July 1, 1987, when SSI recipients become ineligible for SSI because of entitlement to, or an increase in, title II disabled adult child (DAC) benefits, Medicaid eligibility must continue if these individuals continue to meet SSI criteria except for the change in their title II benefit.

1. Eligibility Criteria

The law applies to individuals who are:

- over 18, and
- received SSI after July 1, 1987, and
- became disabled before age 22, and
- receives or begins receiving child's insurance benefits, i.e., receives benefits from a parent's record

When the child's insurance (DAC) benefits either begin or increase and this results in SSI termination for the individual, then Medicaid continuation as a DAC is possible if eligibility for SSI continues on all factors other than income. The DAC will be entitled to a disregard of either the increase in DAC benefits or the full amount of DAC benefits, whichever caused SSI termination.

2. SDX Notification

SSA has the responsibility to notify States about members of this group through the SDX, The "Medicaid Eligibility Code" field of SDX will contain a "D" for individuals potentially eligible for DAC status. Affected individuals are advised to apply for Medicaid when their SSI eligibility is terminated.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED FORMER SSI RECIPIENTS

F. OBRA WIDOW(ER)S

In the Omnibus Budget Reconciliation Acts of 1987 (P.L. 100-203) and 1990 (P.L. 101-508), Congress permanently revised the special, more restrictive disability standard for disabled widow(er)s to the disability standard that applies to all title II and SSI adult disability applicants.

OBRA-87 mandated Medicaid coverage for certain widow(er)s age 60-65 effective July 1, 1988 and after. OBRA-90 mandated Medicaid eligibility for certain widow(er)s age 50-59 effective January 1, 1991. Both widow(er) groups have the same eligibility criteria.

1. Eligibility Criteria

To be eligible as an OBRA-87 or OBRA-90 widow(er), an individual must:

- continue to be eligible for SSI but for their title II benefits;
- received an SSI payment the month before title II payments began; and
- not be entitled to Medicare.

2. Medicare Eligibility

Normally, age 65 will be the effective date for Medicare entitlement; however, there are exceptions such as:

- A widow/widower aged 60 or over may require renal dialysis or a kidney transplant. If this should occur, she/he could become entitled to Medicare on the deceased spouse's Social Security Number (SSN) under the renal provisions. Entitlement to Part A under these provisions could begin the month the beneficiary enters a hospital in anticipation of a transplant, or a third month after dialysis begins.

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- A widow/widower aged 60 or over may be concurrently drawing SSA disability benefits on her/his own SSN. Entitlement to Medicare based on the disability would begin with the 25th month of entitlement to such benefits.

- Section 5103 of OBRA-90 provides that each month of eligibility for SSI will count toward the individual's five-month disability waiting period and 24-month Medicare waiting period. This means that the normal wait for entitlement to disability benefits and/or Medicare can be greatly reduced or even eliminated, depending on the length of time the individual has been receiving SSI benefits. This means that individuals who meet the eligibility criteria described above for OBRA widow(er)s may or may not actually be eligible for Medicaid, depending on when they become entitled to Medicare based on a reduced waiting period.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO "AT-HOME" COVERAGE GROUPS

A. GENERAL DESCRIPTION

The following coverage groups are limited to those who live "at-home" or in other private living arrangements whose income eligibility is based on a percentage of the Federal Poverty Level (FPL). The FPL is updated annually as required by Sections 652 and 673 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and reflects the previous year's change in the Consumer Price Index.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
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B. POVERTY LEVEL AGED & DISABLED (PLAD) GROUP

Section 9402 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) allowed states the option to offer Medicaid coverage to aged and disabled individuals with incomes up to a state-established threshold that does not not exceed 100 percent of the federal poverty level. The resource limits are mandated to be the same as SSI resource limits for this optional group.

Note: Individuals who are blind are ineligible for coverage in this category unless the blind individual is also disabled.

1. Eligibility Criteria

Effective July 1, 1989, an individual or couple must meet all of the following criteria in order to qualify for PLAD coverage:

- The eligible must be aged 65 or over or disabled.
- Income must not exceed the FPL in accordance with the phase-in requirement contained in State law:

85% of the FPL effective 07-01-89
90% of the FPL effective 01-01-90
100% of the FPL effective 01-01-91
135% of the FPL effective 07-01-2000

The income limits apply to countable income, i.e., all appropriate income exclusions apply prior to testing income against the individual or couple level. The income limits for PLAD individuals and couples are listed in the "Chart of Need Standards and Resource Limits" located in the Appendix.

Effective 07/01/00, resources must not exceed $4,000 for an individual and $6,000 for a couple. Effective 07/01/99 - 06/30/00, resources could not exceed $3,000 for an individual and $4,000 for a couple. Effective 07/01/89 - 06/30/99, resources could not exceed SSI resource limits.

- All other non-financial requirements of Medicaid eligibility must be met.

2. Effective Date of Benefits

Medicaid benefits for PLAD coverage is effective with the first of the month in which all factors of eligibility are met, which includes up to 3 months prior to the month of application. However, benefits cannot begin any earlier than July 1, 1989, which is the implementation date for this coverage group.

PLAD eligibles receive full Medicaid benefits.

3. 12-Months Continuous Eligibility

The Balanced Budget Act of 1997, P.L. 105-33, gives states the option to provide continuous eligibility to children under age 19.

Continuous Medicaid applies only to children in any coverage group available to children except children who are only eligible in LTC. When discharged, child would not be automatically eligible for 12 months continuous eligibility from the date last determined eligible.

Children can not be eligible for continuous Medicaid prior to July 1, 1998, which is the effective date of this policy.

After eligibility for Medicaid is determined or redetermined, eligibility will continue for 12 months regardless of changes in circumstances.

4. Termination of PLAD Program

House Bill 1104 passed during the 2005 Legislative Session terminated the Poverty Level Aged and Disabled (PLAD) coverage group effective December 31, 2005.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO "AT-HOME" COVERAGE GROUPS

C. QUALIFIED MEDICARE BENEFICIARIES (QMB'S)

Section 301 of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) mandates coverage of Qualified Medicare Beneficiaries (QMB's) for the purpose of Medicare cost-sharing expenses. The QMB provision of federal law was effective January 1, 1989; however Mississippi requires state enabling legislation prior to adding any new Medicaid coverage group. State legislation delayed implementation of the QMB provision until July 1, 1989.

1. Eligibility Criteria

Effective July 1, 1989, an individual or couple must meet all of the following criteria in order to qualify for QMB coverage:

- The eligible must be entitled to Medicare Hospital Insurance under Part A.

  Note: Individuals with Medicare Part B only who have access to Part A can be considered for QMB eligibility since Medicaid will enroll the individual in Part A and pay the Part A premium.

- Income must not exceed the FPL in accordance with the phase-in requirement contained in State law:

  85% of the FPL effective 07-01-89
  90% of the FPL effective 01-01-90
  100% of the FPL effective 01-01-91

The income limits apply to countable income, i.e., all appropriate income exclusions apply prior to testing income against the individual or couple level. The income limits for QMB individuals and couples are listed in the "Chart of Need Standards and Resource Limits" located in the Appendix.

- Effective 07-01-99, there will be no resource test. Effective 07-01-89 - 06-30-99, resources could not exceed twice the SSI resource limits.

- All other non-financial requirements of Medicaid eligibility must be met.

Note: It is not necessary to verify disability via a DDS decision for a QMB applicant since Medicare entitlement ensures an individual below age 65 is disabled.

2. Medicare Cost-Sharing Benefits

Individuals or couples eligible as QMB's alone are not eligible for full Medicaid services. QMB's receive only Medicare **c**ost-sharing benefits that consists of Medicaid payment for:

- Monthly premiums for Medicare, Part B and, where applicable, for Premium Hospital Insurance under Medicare, Part A.

- Medicare Part A and B deductibles and coinsurance.

3. Effective Date of Benefits

Medicare cost-sharing benefits are effective with the month after the month in which a determination is made that the individual is a QMB. For example, an applicant approved in September will have QMB entitlement effective October 1.

Retroactive benefits are not available for QMB-only eligibles. Benefits cannot begin until the month after the month of approval of the QMB application.

4. Dual Eligibility for QMB's

It is possible for an individual or couple to be eligible as a as a QMB and eligible under another Medicaid coverage group. Eligibility as a QMB can constitute an eligibility status which is in addition to eligibility under another Medicaid coverage group for individuals who can be eligible under more than one group.

When an individual is eligible as a QMB and under another category, this is known as QMB dual eligibility. Those who are dually eligible receive the full range of Medicaid services and Medicare cost-sharing benefits also.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO "AT-HOME" COVERAGE GROUPS

Eligibility for other Medicaid coverage groups is determined using the eligibility criteria for that group, including 3-months retroactivity. In turn, eligibility for QMB status is determined using the eligibility criteria specified for QMB's. If the criteria for both groups is met, the individual is dually eligible.

Example 1: An aged applicant in a nursing home has $1,000 in resources and $400 in total income. The applicant is unmarried and has Medicare, Part A and B. This individual is dually eligible as a nursing home recipient and a QMB since the criteria for both groups is met.

Example 2: Same situation as Example 1 but applicant has $5,000 in resources. This individual can be a QMB only until resources are reduced below the limit of $3,000 required for a nursing home eligible individual.

Example 3: A disabled applicant with full Medicare coverage lives in his own home and has gross income of $550 per month and resources which total $1,900. This individual is dually eligible as a PLAD and a QMB since the criteria for both groups is met.

Example 4: Same situation as Example 3 but applicant has $4,900 in total resources. This individual can be a QMB only until resources are reduced to the $3,000 resource limit at which time he can be dually eligible as a PLAD eligible and a QMB.

If an individual does not specifically and voluntarily choose to have his eligibility determined under one category only, and the individual would be eligible both as a QMB and under another category of eligibility, the worker must make him dually eligible, as outlined below.

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MAO "AT-HOME" COVERAGE GROUPS

5. Applicant's Choice of Category

An individual who would be eligible as a QMB and under eligibility group (including cash assistance) may choose to have eligibility determined only under one category. However, the individual is not required to make such a choice. The applicant is entitled to have eligibility determined under all categories for which he may qualify.

The worker must provide full and complete information to an applicant about the benefits available for each group for which the individual may be eligible prior to any choice of category. Also inform the applicant of his right to have eligibility determined for all categories of Medicaid eligibility.

Note: An individual or couple with income below the SSI FBR may choose to apply for Medicaid only as a QMB and/or PLAD eligible.

6. QMB Dual Benefits

Medicaid currently pays Medicare Part B monthly premiums and Medicare Parts A and B deductible and coinsurance expenses for all Medicaid recipients who have Medicare Parts A and B, regardless of their source of eligibility or coverage group. The only advantage to QMB dual eligibility is to those enrolled in Premium Hospital Insurance under Part A of Medicare. As a QMB Dual, Medicaid will pay the Part A monthly premium. Without QMB Dual status, Medicaid will not pay the Part A premium for Medicaid recipients.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO "AT-HOME" COVERAGE GROUPS

D. SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES

Section 4501 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) mandates coverage of Specified Low-Income Medicare Beneficiaries (SLMB's) for the purpose of paying Medicare Part B premiums. Federal and State legislation mandating this group is effective January 1, 1993.

1. Eligibility Criteria

Effective January 1, 1993, in order to be eligible as an SLMB, an individual or couple must meet all of the following criteria:

- The eligible must be entitled to Medicare Hospital Insurance under Part A. For SLMB purposes, an individual must have <u>active</u> Part A since Medicaid cannot enroll an SLMB eligible in Part A.

  <u>Note</u>: If an individual has Part A <u>but no Part B</u>, the individual can be considered for SLMB eligibility since Medicaid will enroll the individual in Part B and pay the Part B premium.

  If an individual has <u>Part B only</u> (no Part A) then SLMB eligibility is not possible.

- Income must not exceed the FPL in accordance with the following phase-in requirement contained in federal law:

  110% of the FPL effective 01-01-93
  120% of the FPL effective 01-01-95

  The income limits apply to countable income, i.e., all appropriate income exclusions apply prior to testing income against the individual or couple limit. The income limits for SLMB individuals/couples are listed in the" Chart of Need Standards and Resource Limits" located in the Appendix.

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Effective 07-01-99, there is no resource test for this coverage group. Effective 01-01-93 - 06-30-99, resources could not exceed twice the SSI resource limits.

- All other non-financial requirements of Medicaid eligibility must be met.

  Note: A separate disability decision by DDS is not required for applicants under age 65. Entitlement to Medicare ensures the individual is disabled.

2. Payment of Part B Premiums

Individuals or couples eligible as SLMB's qualify for payment of their Medicare Part B premiums only. Medicare Part B is for Supplemental Medical Insurance (SMI).

3. Effective Date of Benefits

Payment of an SLMB's Part B premium is effective with the first month in which all eligibility factors are met, which includes up to 3 months prior to the month of application. Benefits cannot begin prior to 01-01-93, which is the implementation date for this coverage group.

Distinctions Between QMB & SLMB Regarding Medicare Parts A/B

QMB	SLMB
Can have Part A-only (Buy-In will currently "manually" enroll the individual in Part B upon notification to State Office.	MUST have active Part A
Can have Part-B only (Buy-In will automatically enroll the individual in Part A)	CANNOT have Part-B only
Can have Parts A & B	CAN have Parts A & B

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO "AT-HOME" COVERAGE GROUPS

E. QUALIFYING INDIVIDUALS

Section 4732 of the Balanced Budget Act of 1997 (P.L. 105-33) established two new mandatory eligibility groups of low-income Medicare beneficiaries, called Qualifying Individuals (QI's) . This provision amends section 1902(a) (10)(E) of the Social Security Act concerning Medicare cost-sharing for Qualified Medicare Beneficiaries (QMB's) and Specified Low-Income Medicare Beneficiaries (SLMB's). It also amends section 1905(b) of the Act concerning Federal Medical Assistance Percentage (FMAP) by establishing a new section 1933 for QI's.

This provision is effective for Medicare Part B premiums payable beginning with January 1998 and ending with December 2002. Each State will receive a capped allocation for each of the 5 years for the purpose of paying for the Medicare Part B premiums, or a portion thereof, of both groups. Each State must permit all QI's to apply for assistance; however, because of the capped allotment, QI's will be selected on a first come, first served basis. The total number of QI's selected in a calendar year will be limited so that the aggregate amount of benefits provided to QI's in a calendar year will not exceed the State's allocation.

1. Qualifying Individuals-1 (QI-1 Group)

Effective January 1, 1998, in order to be eligible as a QI-1, an individual or couple must meet the following criteria:

- The individual must be entitled to Medicare Hospital Insurance under Part A. Just as for SLMB's, this means the individual must have <u>active</u> Part A.

- Effective 07/01/99, there is no resource test. Effective 01/01/98 - 06/30/99, the resources could not exceed twice the SSI resource limit.

- The income limit is above 120% but less than 135% of the Federal Poverty Level (FPL). The income limits are listed in the "Chart of Need Standards and Resource Limits" located in the Appendix.

- All other non-financial factors of Medicaid eligibility must be met; however, no separate DDS decision is required.

Individuals who qualify as a QI-1 will have their Medicare, Part B premiums paid the same as SLMB eligibles. The difference between the SLMB and QI-1 coverage groups is that QI-1's have a higher income limit with a 100% federal match for the Part B premiums paid on a first come, first serve basis.

2. Qualifying Individuals-2 (QI-2 Group)

Effective January 1, 1998, in order to be eligible as a QI-2, an individual must meet all of the same criteria as a QI-1 except for income. The income limit for QI-2's is at least 135% but not exceeding 175% of the Federal Poverty Level (FPL). The income limits are listed in the "Chart of Need Standards and Resource Limits" located in the Appendix.

Individuals who qualify as a QI-2 will be entitled to a partial payment of their Medicare Part B premiums. The Medicare Part B portion that is attributable to the shift of some home health benefits from Part A to Part B will be paid directly to the eligible at year's end. The payment represents a refund of overpayment of Part B premiums they have already paid.

Federal law terminated the QI-2 Program effective 12-31-02.

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MAO "AT-HOME" COVERAGE GROUPS

E. QUALIFIED WORKING DISABLED INDIVIDUALS (QWDI's)

Section 6408 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) requires States to provide Medicaid to certain qualified disabled and working individuals for the purpose of paying Medicare cost sharing expenses. Medicare cost sharing expenses are limited to payment of Medicare Part A premiums only.

1. SSA's Eligibility Criteria

Section 6012 of OBRA-89 makes Medicare available to working disabled individuals whose disability insurance benefits (DIB) terminated because of work, even though their disabling condition did not improve. This provision of federal law allows the disabled individual to purchase Medicare Part A Hospital Insurance Benefits (Premium HI).

The Social Security Administration (SSA) will make the initial eligibility determination for individuals potentially eligible for Premium HI. These individuals must meet all of the following criteria:

- The individual must be under age 65,
- Have been entitled to disability insurance benefits (DIB) under title II,
- Continue to have a disabling physical or mental condition,
- DIB ended due to earnings exceeding the substantial gainful activity (SGA) limits, and
- Not otherwise eligible for Medicare.

An individual who loses DIB due to SGA but continues to be disabled can continue Medicare coverage for several months (generally up to 24 months). Premiums for the supplemental medical insurance portion of Medicare (Part B) are payable by the disabled individual during this time.

At the time this extended (free Part A) Medicare coverage ends, SSA will mail the disabled individual a notice informing him/her of the right to enroll for Premium HI under this new federal law. The individual has 7 months to enroll for Premium HI beginning with the month of the notice. If the individual does not enroll during this 7 month period, the next enrollment period is the general enrollment period which is January - March of each year. Delayed enrollment (during general enrollment) will result in a delay in entitlement effective the following July 1.

A disabled individual who meets all of the criteria used by SSA can enroll and pay his/her Part A and B premiums after DIB terminates and "free" Part A of Medicare terminates. Out of this group of disabled working individuals, some can qualify for Medicaid to pay their Part A premiums if the Medicaid criteria specified below is met.

2. Medicaid's Eligibility Criteria

Effective July 1, 1990, a Qualified Working Disabled Individual (QWDI) (as defined by SSA criteria outlined above) can apply with the appropriate Medicaid Regional Office and become eligible for Medicaid to pay his/her Medicare Part A premium if all of the following criteria is met:

- The individual must be "entitled to enroll" for Medicare Part A hospital insurance benefits under Section 6012 of OBRA-89.

- The individual must have income that does not exceed 200% of the federal poverty level (FPL). The income limits for QWDI individuals and couples are listed in the "Chart of Need Standards and Resource Limits" located in the Appendix.

- Effective 07-01-99, there is no resource test. Effective 07-01-90 - 06-30-99, the resources could not exceed twice the SSI resource limit.

- The individual is not otherwise eligible for Medicaid under any other existing coverage group.

- All other non-financial requirements for Medicaid eligibility must be met.

Note: A separate disability decision by DDS is not required since continuing entitlement to Medicare ensures disability.

3. Effective Date of Benefits

The effective date of benefits under this provision is based on the date of application and the date on which all eligibility criteria are met, including enrollment for Medicare Part A. For example, if an individual applies for benefits on October 1, and is already enrolled in Medicare Part A, eligibility can be effective October 1 (or up to 3 months prior to October 1, if all eligibility criteria was met during the 3-month period). However, if in this example, the individual's enrollment for Part A is not effective until November 1, eligibility as a QWDI cannot be effective until that date. In no case can eligibility as a QWDI be effective prior to July 1, 1990, the effective date of the law.

Note: A QWDI is eligible only as a QWDI. There is no dual eligibility as in QMB eligibility. If a QWDI would qualify under another coverage group, such as PLAD coverage, then the individual should have his/her eligibility determined under the category where the full Medicaid Services are available (or additional Medicare cost-sharing is available such as QMB coverage). Remember, a QWDI will receive payment of Part A monthly premiums as the only Medicaid benefit available under this category. There will be no payment of Medicare Part B premiums, co-insurance or deductibles for QWDI's.

4. Termination of QWDI Benefits

Eligibility as a QWDI may terminate as a result of no longer meeting any eligibility factor. In addition, when a QWDI reaches age 65 or otherwise becomes eligible for free Medicare Part A, eligibility as a QWDI for Medicaid purposes must end. Also, a medical recovery would terminate QWDI eligibility.

- There is no requirement for the eligible to have had a disability determination prior to WD coverage.

- Individuals age 65 or over may be considered for WD coverage, but disability must be determined the same as for someone under 65.

- Individuals who are blind must also be determined disabled.

- Utilization of Other Benefits is not applicable to WD's; however, if coverage changes to another coverage group, Utilization of Benefits apply.

Budget Rules & Income follow SSI criteria as follows:

- The WD eligible may be an individual, a WD couple or a WD eligible with an ineligible spouse, in which case allocations to ineligible children rules apply.

- Mixed Budgeting is not allowed; one member of a couple cannot be tested as a PLAD while the other spouse is a WD.

- Income is budgeted in two separate steps:

  1. Earned income from all sources for the WD and spouse, if any, is combined and earned income disregards are applied. The remaining countable earned income cannot be equal to or exceed 250% of the FPL for an individual or couple, as appropriate.

  2. Unearned income from all sources for the WD and spouse, if any, is combined and the general exclusion applied and remaining unearned income must not be equal to or exceed the SSI FBR for an individual or couple, as appropriate.

Resources must not exceed $3000 for an individual and $4000 for a couple.

All other non-financial requirements of Medicaid eligibility must be met.

2. **Effective Date of Benefits**

Medicaid benefits for WD coverage is effective with the first of the month in which all factors of eligibility are met, which includes up to 3 months prior to the month of application. However, benefits cannot begin any earlier than July 1, 1999, which is the implementation date for this coverage group.

WD eligibles receive full Medicaid benefits.

3. Premiums

Certain individuals eligible for Medicaid as a WD will pay premiums or cost-sharing charges, set on a sliding scale based on earned income. If total countable earned income is less than 150% of FPL, no premium is due. The Sliding Scale for Working Disabled Premiums is located in the appendix.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE "AT-HOME" COVERAGE GROUPS

F. **WORKING DISABLED (WD'S)**

Section 4733 of the Balance Budget Act of 1997, allowed states option to offer Medicaid coverage to disabled working individuals who, because of relatively high earnings, cannot qualify for Medicaid under existing statue (1905(q) (2) (B) under which disabled working individuals may be eligible for medical assistance. Except for their earned income, these individuals would be considered to be receiving SSI benefits (although there is no requirement for the individual to have ever received SSI).

1. **Eligibility Criteria**

Effective July 1, 1999, the following criteria must be met in order for an individual or couple to qualify for working Disabled (WD) coverage.

"Working" means that the disabled individual must be engaged in some type of work activity that earns at least $500 per month in gross earnings.

- the number of hours employed will not be a factor nor the type of work; however, the minimum gross earning thresh hold of $500 per month must be met

- each individual who applies must be working to be considered. If a couple wants coverage, both must be disabled and working and each must earn $500

"Disabled" means the individual meets the SSI disability criteria except for the application of "substantial gainful activity" (SGA) criteria. The fact that the individual is working is not to be considered in making the disability decision.

- Disability decisions for applicants who do not receive a disability benefit will be determined by DDS. Refer cases to DDS in the usual manner described in Section D; however, the DOM-325 Form must be clearly notated that it is a request for a "Working Disabled" decision. This is the only way DDS will know to ignore SGA.

- There is no requirement for the eligible to have had a disability determination prior to WD coverage.

- Individuals age 65 or over may be considered for WD coverage, but disability must be determined the same as for someone under 65.

- Utilization of Other Benefits is not applicable to WD's; however, if coverage changes to another coverage group, Utilization of Benefits apply.

Budget Rules & Income follow SSI criteria as follows:

- The WD eligible may be an individual, a WD couple or a WD eligible with an ineligible spouse, in which case allocations to ineligible children rules apply.

- Mixed budgeting is not allowed; one member of a couple cannot be tested as a PLAD while the other spouse is a WD.

- Income is budgeted in two separate steps:

    1. Earned income from all sources for the WD and spouse, if any, is combined and earned income disregards are applied. The remaining countable earned income cannot be equal to or exceed 250% of the FPL for an individual or couple, as appropriate.

    2. Unearned income from all sources for the WD and spouse, if any, is combined and the general exclusion applied and remaining unearned income must not be equal to or exceed the SSI FBR for an individual or couple, as appropriate.

Resources must not exceed $3000 for an individual and $4000 for a couple.

All other non-financial requirements of Medicaid eligibility must be met.

2. **Effective Date of Benefits**

Medicaid benefits for WD coverage is effective with the first of the month in which all factors of eligibility are met, which includes up to 3 months prior to the month of application. However, benefits cannot begin any earlier than July 1, 1999, which is the implementation date for this coverage group.

WD eligibles receive full Medicaid benefits.

3. **Premiums**

Certain individuals eligible for Medicaid as a WD will pay premiums or cost-sharing charges, set on a sliding scale based on earned income. If total countable earned income is less than 150% of FPL, no premium is due. The Sliding Scale for Working Disabled Premiums is located in the appendix.

4. **Liberalized Policy**

Effective July 1, 2000, the definition of "working" will be changed to paid activity of a minimum of 40 hours per month. The amount of money earned will not be a factor nor the type of work; however, the minimum of 40 hours per month must be met.

If a couple wants coverage, both must be disabled and each must be working 40 hours per month.

Effective July 1, 2000, the maximum unearned income limit will be 135% of the Poverty Level. The Poverty Level chart is listed in the appendix.

Effective July 1, 2000, resources must not exceed $4,000 for an individual and $6,000 for a couple.

Effective April 1, 2001, resources must not exceed $24,000 for an individual and $26,000 for a couple. July 1, 2000 through March 31, 2001, resources could not exceed $4,000 for an individual and $6,000 for a couple.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
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G. BREAST AND CERVICAL GROUP

State legislation passed during the 2001 session contained provisions for Medicaid to provide coverage for women diagnosed with breast or cervical cancer.

1. Eligibility Criteria

Effective July 1, 2001, in order to be eligible for this coverage group, an individual must meet the following criteria:

- Be a woman under the age of 65
- Have no other creditable health insurance
- Have household income under 250% of the Federal Poverty Level
- Have been screened for breast and cervical cancer by the Centers for Disease Control (CDC) and Prevention's Breast and Cervical Cancer Early Detection Program.

The State Department of Health (SDH) has the responsibility for the screening program; however, they may contract with outside providers to perform the actual screening.

The eligibility input will take place at the State Office (SO) level. The SDH will fax information to the State Office (SO) of the Eligibility Bureau confirming a cancer diagnosis for a woman who has been screened through the CDC program. Eligibility will be placed on file immediately and the woman will be eligible for full service Medicaid for the course of her treatment or until she reaches 65 and becomes Medicare eligible.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
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A. GENERAL DESCRIPTION

The following describes coverage groups of eligibles who live "at-home" or in a type of private living arrangement; however, due to the nature of their illness or disability their eligibility is evaluated using "Long Term Care" or institutional policy requirements. Institutional policy rules allow a higher income limit and resource rules for married couples and children that are more conducive to allowing a greater number of eligibles to qualify.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE "AT-HOME" COVERAGE GROUPS

B. DISABLED CHILDREN LIVING AT-HOME

Section 134 of the Tax Equity and Fiscal Responsibility Act Responsibility Act of 1982 (P.L. 97-248) allowed States, at their option, to make benefits available to children (age 18 or under) living "at-home" who qualify as disabled individuals provided certain conditions are met. These children would not ordinarily be otherwise eligible for Medicaid due to the deeming of parental income or resources. The specific statutory provisions establishing this option are contained in Section 1902(e) of the Social Security Act. State enabling legislation established authority for coverage of Disabled Children Living At-Home (DCLH) effective July 1, 1989.

1. Eligibility Criteria

Effective July 1, 1989, in order for a child to establish Medicaid eligibility under this coverage group, all of the following conditions must be met.

- The child must be determined disabled according to SSI criteria by the Disability Determination Service (DDS).

- The child must require the level of care provided in a hospital, nursing facility or an intermediate care facility for the mentally retarded (ICF-MR) as determined by medical staff with the Division of Medicaid.

- The child must be determined eligible for Medicaid using the same criteria as is used for nursing home applicants.

- It must be appropriate to provide care to the child at home and the estimated cost of care at home must be no more expensive than the estimated Medicaid cost of institutional care.

The Regional Offices will process applications for Medicaid coverage under this provision in the same manner as applications for nursing home care. The child is treated as though he/she were actually in long-term care, i.e., the child's financial eligibility is based on the child's own income and resources.

THERE IS NO DEEMING OF PARENTAL INCOME AND RESOURCES TO THE ELIGIBLE CHILD IN ANY MONTH. The income limit for the child's own income is the institutional maximum and the resource limit for the child's own resources is the individual SSI resource limit.

2. Level of Care Decision

A level of care decision is required for disabled children at home just as if the child were in long-term care in a medical facility. The level of care (LOC) decision is in addition to the DDS disability decision that is also required. The LOC decision process for a disabled child at home is handled differently from on-going nursing home LOC decisions and requires Regional Office involvement in obtaining the decision. The procedure is as follows:

a. The Regional Office will remain a supply of DOM-260DC Forms entitled "Medicaid Certification for Disabled Children Living-At-Home," which is the form used to evaluate LOC criteria.

b. The Regional Office will provide the child's family with a DOM-260DC Form and a DOM-323A, Disabled Child Questionnaire, along with a "Disabled Child Living At-Home Information Sheet" which explains the requirement for completion of these 2 forms at each application and redetermination. The Information Sheet advises the parent or guardian to have the child's physician complete the DOM-260DC and include current medical information for the child. The medical information must be dated within the prior 12 months and must address or update the child's primary disability.

   The DOM-323A, Disabled Child Living At-Home Questionnaire, is also addressed on the Information Sheet and must be included with the DOM-260DC. It is a required form for DDS purposes and for review by medical staff in the Maternal Child Health Unit for DCLH coverage.

When the DOM-260DC and the DOM-323A Forms have been completed by the physician and parent (or guardian), the forms must be returned to the Regional Office for handling.

c. The Regional Office will forward the completed DOM-260DC with the current medical information and the DOM-323A to the Maternal Child Health (MCH) Unit of the State Office by way of a "Disabled Child Living At-Home Transmittal Sheet" containing identifying information about the child along with any comments about the case. The form will be reviewed by medical staff in the MCH Division who are responsible for making level of care decisions.

d. The Maternal Child Health Unit will render the LOC decision and return the DOM-260DC Form to the Regional Office with a LOC decision. If the LOC decision is approved, the application for Medicaid can be approved if the child is eligible on all other factors. A disapproved DOM-260DC Form will result in a Medicaid denial.

   If there is not sufficient medical information to make a level of care decision, the forms will be returned to the Regional Office with an "Unable to Process" decision. The additional information needed to make a decision will be specified. The Regional Office will relay this information to the parent or guardian by way of DOM-307 and 309.

   If the requested information is provided, the Regional Office will forward all new and previously returned information to the MCH Unit for a final decision.

e. The Regional Office will send the MCH Unit a copy of the Notice of Action (approving or denying eligibility) at the time of each application and redetermination so that the MCH Unit can file the notice with their records.

3. Review Intervals

MCH has developed a review system that will utilize two review intervals, **one-year and three-year**. The criteria for determining intervals are:

One-year - Improvement is expected in the condition, currently requiring an institutional level of care, or the course of this condition is unpredictable. Examples include but are not limited to:

- all malignancies
- all mental disorders
- all developmental delays
- all conditions requiring surgery within one year
- unstable seizure disorders

Three year - The condition may improve, but improved results cannot be expected to require less than an institutional level of care based on current experience. Examples include but are not limited to:

- Mental retardation with IQ of 59 or less as determined by qualified mental health professionals per DSM-IV criteria.
- End Stage Renal Disease diagnosis by a Urologist.
- Permanently and totally impaired mobility uncorrected by prosthesis. (Wheelchair bound)
- Full thickness burns to 10% or more of total body surface.

- Organ or bone marrow transplant within the last 12 months.

- Autism

- Pervasive Developmental Delay

Regional Offices must send the DCLAH review to MCH when the review is due. When the DCLAH is admitted to a facility, check to see if a review may be due when the child is discharged.

4. Effective Date of Benefits

Medicaid benefits are effective for the DCLH coverage group effective with the month in which all factors of eligibility are met, which includes up to 3 months prior to the month of application.

DCLH eligibles receive full Medicaid benefits.

5. 12-Months Continuous Eligibility

Effective July 1, 1998, children under age 19 will continue Medicaid eligibility for 12 months regardless of changes in circumstances. Exceptions to this rule:

- child reaches age 19

- child moves out of state or is admitted to a public institution

- child dies

- family requests voluntary closure

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C. HOSPICE CARE

Section 9505 of the Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99-272) amended title XIX of the Social Security Act to permit hospice care benefits to be provided, at State option, to individuals eligible for Medicaid including a newly created hospice care eligibility group. In order for individuals to receive hospice care they must be medically verified as terminally ill and voluntarily elect to receive hospice care in lieu of certain other Medicaid benefits. Upon the election of hospice care, Medicaid begins reimbursement to the hospice provider for each day the election for hospice care is in effect, subject to an overall maximum reimbursable.

Coverage of hospice services by Mississippi Medicaid for individuals eligible under ongoing coverage groups was effective July 1, 1991.

1. Hospice Care Eligibility Group

Section 9505 (b)(2) of Public Law 99-272 established a new optional categorically needy eligibility group for individuals who elect hospice care. Eligibility under this group is determined using the same eligibility criteria and special income standard (300% of the SSI FBR for an individual) that is used for long term care cases regardless of whether the hospice client lives in a private living arrangement or a free standing hospice care facility. Coverage of the optional hospice care eligibility group by Mississippi Medicaid is effective April 1, 1993.

2. Eligibility Criteria

An individual may be eligible under any existing at-home coverage group and elect hospice care benefits if determined to be terminally ill. The election for hospice services is handled by the hospice provider. If eligibility exists under an "at-home" category (SSI, AFDC or PLAD eligibility), there is no need to change the recipient's eligibility to the hospice care group. The recipient can receive hospice services without applying for the hospice care eligibility group.

An application for hospice care eligibility is required if an individual is not already Medicaid eligible and cannot be eligible for Medicaid except by using long term care eligibility criteria. In determining eligibility for hospice care, use the same financial and non-financial rules that apply for long term care (LTC) coverage groups just as if the hospice care applicant was in a medical institution. Spousal Impoverishment income and resource rules apply even though the applicant may live in the same household with his/her spouse. The difference between long term care and hospice care criteria is as follows:

- No DDS decision is required since the hospice provider is required to obtain a medical prognosis of a terminal illness before hospice services can be elected.

- No 260 Form is required. Instead a copy of the "Hospice Membership Form" must be obtained by the Regional Office from the hospice provider.

- The hospice care eligible has no Medicaid Income payable because the Personal Needs Allowance (PNA) is set at the Community Spouse Monthly Maintenance Needs Allowance maximum. Since this maximum standard is higher than the 300% income limit, no Medicaid Income is payable. The CS MMNA is allowed as the PNA for each hospice eligible, regardless of marital status.

If the individual is in LTC prior to converting to Hospice coverage, a 317 is required to discharge the individual from the facility; and the Enrollment Form is required to show the effective date of Hospice. When a Hospice individual enters a nursing facility and wants LTC coverage, an Enrollment Form is required to verify disenrollment from Hospice care.

A 317 is needed to verify admission to the facility. If an individual has Hospice coverage and enters a nursing home but does not want LTC coverage, no action is required.

Any LTC dates in REHF that correspond to Hospice eligibility prevent Hospice claims from paying. Therefore, Hospice coverage must begin the month after LTC Liability has ended. If an individual is changing from Hospice to LTC coverage, the Hospice coverage must end the month prior to the LTC coverage.

3. Effective Date of Eligibility

The special income standard (300% of the SSI FBR) is directly related to the 30-consecutive day requirement whereby an individual must remain in long term care for at least 31 days before the higher need standard can be applied. By definition, individuals potentially qualifying under the hospice care eligibility group are not in an institution so they cannot literally fulfill the 30-consecutive day requirement. However, in order to be eligible to receive hospice care, individuals must file an election statement (Hospice Membership Form) with a particular hospice. That hospice will be reimbursed by Medicaid for each day the election for hospice care is in effect, regardless of whether or not the individual actually receives services from the hospice. The beginning date of reimbursement is the effective date of the hospice election.

In applying the 30-consecutive day requirement of the hospice care group, day one is the effective date of the hospice election. If the election is in effect for a full 30-consecutive day period, eligibility using the higher income standard for long term care (300%) may be applied retroactive to the effective date of the hospice election. Eligibility can begin with the first of the month of the hospice election provided the individual is eligible on all other factors. The exception to fulfillment of the 30-consecutive day requirement is death during the 30-day period.

There may be situations where the 30-consecutive day requirement has already been met by an individual. In such cases, the individual electing hospice care does not need to meet the 30-consecutive day requirement again in order to apply the special income standard. For example, an individual living in a medical facility (hospital or nursing facility), who has already been determined eligible using the higher institutional income limit, may elect hospice benefits.

As long as there is no break in time between eligibility in the institution and the effective date of the election for hospice care, eligibility under the hospice care eligibility group can begin the month after the hospice election.

4. **Hospice Membership Form**

When a Medicaid recipient or applicant for hospice care eligibility elects hospice services, the "Hospice Membership Form" must be completed. By completion of this form, the hospice patient elects hospice care in lieu of Medicaid payments made for treatment of the condition for which the hospice care is sought. The hospice provider obtains the client's signature on the form and also obtains the physician's prognosis of the illness.

5. **Termination of Hospice Care Eligibility Coverage Group**

House Bill 1104 passed during the 2005 Legislative Session terminated the eligibility category for the optional hospice care coverage effective May 1, 2005. After May 1, 2005, individuals eligible in another eligibility category may receive hospice as a covered service only. The election for hospice services is handled by the hospice provider.

6.	**Transfers Between** completed **LTC and** must **Hospice**	If an individual is changing from LTC to Hospice or vice versa, the Regional Office must obtain a copy of the and signed Hospice Membership Form. Also, the 317 be obtained from the nursing home to verify admission or discharge.

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D. HOME & COMMUNITY BASED SERVICES (HCBS) WAIVER PROGRAMS

The Division of Medicaid has been granted the authority under Section 1915 (c) of the Social Security Act to implement Home & Community Based Services (HCBS) Waiver Programs. The waiver program is limited to individuals who meet the nursing home level of care or ICF/MR level of care but choose to remain at home. Individuals eligible for the waiver programs will receive all regular Medicaid services in addition to the waiver services. The following coverage groups are limited to those who qualify for the waiver program:

1. HCBS Independent Living Waiver (IL)

The approval of the HCBS Handicapped Waiver created a new coverage group for certain individuals who participate in this program. Coverage of this new eligibility group is effective January 1, 1994. The individual must meet the following criteria in order to qualify for the Independent Living coverage:

- Disabled individuals of any age.

- Individuals whose handicap consists of severe orthopedic and neurological impairments that render the individual dependent upon others, assistive devices, other types of assistance or a combination of these to accomplish the activities of daily living. The individual must be able to communicate effectively with the caregiver and service provider.

- Would require a nursing home level of care if assistance is not provided.

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The initial point of contact for participation in this program is the Department of Rehabilitation Services (DRS). DRS staff has the responsibility of assessing an individual's medical potential for participation in this group and for completion of Form DOM-260HCBS Physician's Certification for Medicaid Home and Community Based Services Program. A completed DOM-260HCBS Form is then forwarded to the DOM Community Long Term Care Unit where medical review staff will render the final decision regarding medical eligibility for the Independent Living (IL) group.

A list of the Mississippi Department of Rehabilitation Services (MDRS) offices is located in the appendix.

Services offered through this waiver program include personal care attendant services, and case management, as well as all the other benefits that a full service Medicaid recipient would receive.

2. Elderly and Disabled Waiver (E&D)

The Elderly and Disabled Waiver is a satewide program that provides home and community based services to individuals over the age of 21. The individual must meet the following criteria to be eligible for this coverage group:

- Be age 21 or older

- Have deficits in at least three activities of daily living (ADL) such as: Eating, toileting, bathing, personal hygiene, ambulation, transferring and dressing. Must meet a nursing facility level of care.

The initial point of contact for participation in this program is the Area Agency on Aging (AAA). Case Management services are provided by the Area Agencies on Aging/Planning and Development Districts. The case management team is composed of a registered nurse and a licensed social worker who are responsible for identifying, screening and completing an assessment on individuals in need of at-home services.

A listing of the Area Agencies on Aging is located in the Appendix.

Services offered through the E & D coverage group include:

- Case Management
- Homemaker Services
- Adult Day Services
- Home Delivered Meals
- Transportation
- Institutional and In-Home Respite

3. Mentally **Retarded/ Developmentally Disabled Waiver (MR/DD)**

The Mentally Retarded/Developmentally Disabled (MR?DD) coverage group is a statewide program administered directly by the Department of Mental Health, Bureau of Mental Retardation. To be eligible for this waiver, individuals must meet the following criteria:

- Have a diagnosis of mental retardation or developmental disability

- Without assistance, would require ICF/MR level of care

The initial point of contact for participation in this program is the Department of Mental Health. Referrals may be made directly to the local Regional Centers: Boswell, Ellisville, Hudspeth and North Mississippi Regional Center.

Director names and phone numbers of the Regional Centers are listed in the Appendix.

Services provided through this waiver include: Community and in-home respite; Residential habilitation; Day habilitation; Supported employment; Occupational therapy; Behavioral support and intervention; ICF-MR respite; Attendant care aide; Prevocational services; Physical therapy; Speech, language and hearing services; and, Specialized medical supplies.

4. **Assisted Living Waiver**

The 1999 Legislative required the Division of Medicaid to submit an application to the Health Care Financing Administration (HCFA) for an assisted living waiver. This waiver was approved by HCFA effective October 1, 2000, for individuals in the following counties:

Bolivar	Hinds	Sunflower
Forrest	Lee	
Harrison	Newton	

Individuals must meet the following criteria to be eligible for this waiver program:

- Must be 21 years of age or older

- Must require assistance with at least three Activities of Daily Living (ADL)

- Have a diagnosis of Alzheimer's disease or another type of dementia and need help with at least two activities of daily living (ADL)

Services will be offered in a Level I licensed Personal Care Home that has chosen to participate as a Medicaid Waiver Provider. Services provided through this program include the following: Case Management; Attendant Care; Therapeutic Social and Recreational Programming; Intermittent Skilled Nursing Service; Transportation; Incontinence Supplies; Attendant Call System; Chose Services; Medication Administration; Homemaker Services; Personal Care; and, Medication Oversight.

5. Traumatic Brain Injury and Spinal Cord Injury Waiver (TBI/SCI)

State Legislation passed during the 2001 session created a waiver program to assist individuals who have a traumatic brain or spinal cord injury, who, but for the provisions of such services, would require the level of care provided in a nursing facility.

Effective July 1, 2001, in order to be eligible for this coverage group, an individual must meet the following criteria:

- Have a diagnosis of a traumatic brain injury or spinal cord injury
- Must be medically stable
- Cannot have an active life threatening condition that would require systematic therapeutic measures, IV drip to control or support blood pressure, intercranial pressure or arterial monitoring.

The initial point of contact for participation in this program is the Mississippi Department of Rehabilitation Services. A list of the Mississippi Department of Rehabilitation Services (MRDS) offices is located in the appendix.

Services offered through the TBI/SCI Waiver include:

- Case Management
- In-Home Nursing Respite
- In-Home Companion Respite
- Institutional Respite
- Attendant Care Services
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies

The following eligibility groups are potentially eligible for the TBI/SCI Waiver:

- TANF recipients, SSI recipients, Children under age 19, Foster Children, Disabled Children Living at Home, PLAD eligibles (135%), and 300% FBR income (nursing home limit).

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a. **Eligibility Criteria**

Individuals eligible for Medicaid as an SSI recipient, or PLAD eligible may participate in the HCBS Waiver Program if the individual meets the medical criteria. For those not otherwise eligible for Medicaid through the SSI program, or the Poverty Level, Aged and Disabled (PLAD) Program, eligibility for Medicaid under the HCBS Waiver Program will be determined by Medicaid Regional Offices using the same eligibility criteria and special income standard (300% of the SSI FBR for an individual) that is used for Long Term Care coverage groups. An application for MAO eligibility under the HCBS Waiver Programs is required if an individual is not already SSI or PLAD eligible. All factors of eligibility must be met. If the individual is eligible as an SSI recipient, there is no need to change the recipient's eligibility to the HCBS Waiver Program.

Effective July 1, 2001, PLAD eligible cases will need to be changed to the appropriate HCBS coverage group and ensure that all factors of eligibility are met.

b. **Transfer Penalty**

Effective July 1, 2001, all persons applying for a HCBS waiver program will be subject to the transfer of assets policy and the estate recovery policy provisions. This will include individuals already eligible under the PLAD coverage group who enroll in a HCBS Waiver Program after 07-01-01 as well as the individuals qualifying under the 300% guidelines. Any transfers that occurred prior to July 1, 2001, will not be developed for the HCBS Waiver Programs. Any person who entered the HCBS Waiver Program prior to July 1, 2001, will not have their case reviewed for transfers. Those individuals will be "grandfathered". However, if the individual is discharged from the program and is readmitted after July 1, 2001, the "grandfathered" status is lost. The case will be reviewed as a new HCBS recipient.

c. Application Process

a. The application process is handled as follows:

To begin the application process, the applicant or representative must be advised to contact the agency that is responsible for the specific waiver program:

- Independent Living Waiver-Department of Rehabilitation Services (DRS)
- Elderly & Disabled Waiver-Area Agency on Aging (AAA)
- MR/DD-Department of Mental Health
- Assisted Living-Community LTC at the Division of Medicaid
- Traumatic Brain Injury and Spinal Cord Injury Waiver - Department of Rehabilitation Services (DRS)

Names and phone numbers for each agency are listed in the appendix.

Only those individuals who meet the age and medical criteria should be referred to agency for participation in this program. Do not refer any individuals to an agency who do not meet the basic criteria.

The appropriate agency will initiate the completion of the DOM-260HCBS Form and will send the completed DOM-260HCBS to the DOM Community Long Term Care Unit for approval. The agency will also notify the individual in writing that an application must be filed with the appropriate Regional Medicaid Office within 45 days.

If the Regional Office receives an approved DOM-260HCBS but no application is on file, the Regional Office will send out an application package to the individual. Note: If an application is not filed within 45 days from the date the DOM-260HCBS is approved, the DOM-260HCBS will no longer be valid. The appropriate agency will notify the individual that a new DOM-260HCBS will be required and the effective date will be subject to change. The Regional Office will receive a copy of this notice.

The Regional Office will process the MAO application for Medicaid under the waiver program in the same manner as nursing home applications are processed:

- Use the same financial and non-financial rules that apply as if the applicant was in a nursing facility

- Spousal Impoverishment rules apply even though the applicant may live in the same household with his/her spouse

- A DDS decision is required unless one of the exceptions for obtaining a DDS decision applies.

An approved DOM-260 HCBS Form is required prior to approval of an application documenting the individual's need for the level of care provided by a nursing facility. The Regional Office will be mailed a copy of the completed DOM-260 HCBS from the DOM Community Long Term Care Unit on any MAO applicant for the HCBS Waiver Program. **NOTE:** Eligibility can not begin until the month the physician signs the DOM-260 HCBS.

Upon initial application for the special income category (300%) under the HCBS programs, if eligibility is denied for any reason, the DOM-260HCBS submitted with the initial application is no longer valid. If the applicant requests eligibility determination at a later date, a new DOM260HCBS will be required.

A HCBS and Medicaid Regional Office Two-Way Communication Form will be used to notify each bureau of the appropriate action to be taken on each case. A copy of the two-way communication form will be made a part of the permanent case record in the regional office.

Eligibility in the Waiver Program must be redetermined every 12 months and all factors of eligibility must continue to be met. This includes obtaining a new DOM-260HCBS Form each year to document the continuing need for participation in this program. The redetermination process is initiated in the same manner as the application process, i.e., the client or representative must contact the appropriate agency to initiate the 260 process.

d. Effective Date of Benefits

Eligibility can be established with the month the physician signs the DOM-260HCBS, provided the application was filed timely. Retroactive eligibility is possible (up to 3 months prior to the application month) provided the physician signed the DOM-260HCBS within any of these months. If the DOM-260HCBS is not signed until after the month of application, eligibility cannot begin until the month signed.

e. Post Eligibility Treatment of Income

No post-eligibility treatment of income is required for this this eligibility group. The Personal Needs Allowance (PNA) (PNA) for this group is equal to the institutional income limit (300% of the SSI FBR). As a result, no Medicaid Income is payable by the eligible and it is not necessary to issue a 317 Form to authorize any type of payment to a provider. The eligible individual can use the Notice of Approval and/or Medicaid card to notify providers of eligibility.