

**G-0000 APPLICATION PROCESSING****G-100 INTRODUCTION**

This section contains information on processing applications for medical assistance.

Effective October 1, 2013, in accordance with the Patient Protection and Affordable Care Act of 2010 (ACA), the application must be the single streamlined application. The [BHSF Form 1-A](#) is used to apply for Modified Adjusted Gross Income (MAGI) Medicaid programs.

For individuals who may be eligible for certain non-MAGI programs, the agency has applications specifically designed for the following programs:

- Long-term care (LTC);
- Home and Community-Based Services (HCBS) Waivers;
- Program of All-Inclusive Care for the Elderly (PACE); and
- The Medicare Savings Programs (MSP).

For individuals applying for non-MAGI programs using the [BHSF Form 1-A](#) application, the agency uses supplemental forms to ask questions and collect information needed to determine eligibility on a basis other than MAGI. Individuals shall not be required to reapply.

MAGI methodology is used to determine income eligibility for the following groups:

- Adult age 19-64;
- Children;
- Parents and Caretaker Relatives (PCR);
- Pregnant Women (PW);
- Child-related groups;
- Other adult related groups:
  - Refugee Medical Assistance (RMA);
  - Regular and Spend-Down Medically Needy;
  - Take Charge Plus (TCP); And

- Tuberculosis Infected (TB).

See [I-1550 MAGI Determinations](#) for more information.

**Note:**

Although the term "applicant" is used in this section, this policy also applies to beneficiaries for whom a renewal of eligibility is being completed, as well as to responsible persons acting on behalf of an applicant/beneficiary.

## **G-200 GENERAL INFORMATION**

The local office is required to:

- Provide adequate physical facilities to accommodate applicants and beneficiaries who come to the office, including privacy for interviews;
- Courteously and promptly greet all persons who come to, or contact, the office and refer them to the appropriate staff without unnecessary delay;
- Allow any individual the right to apply for any Medicaid benefit, regardless of circumstances;
- Provide an application form to anyone who requests one and offer assistance completing the application to anyone who requires or requests assistance;
- Provide, as appropriate, the applicant with the agency's website and/or direct the applicant/beneficiary to the on-line application kiosk in the local office lobby;
- Make referrals to agencies and resources that are designed to meet the applicant/beneficiary's needs if those needs cannot be fulfilled by the agency;
- Promptly and without undue delay (and consistent with established timelines) transfer the applicant/beneficiary's electronic account via secure electronic interface to the Federally Facilitated Marketplace (FFM or Marketplace) when the applicant/beneficiary:
  - Is not found eligible for Medicaid using the MAGI methodology; or
  - Is pending a decision in the non-MAGI (formerly Aged, Blind, Disabled or Long-Term Care) categories; and

- Communicate information regarding services offered by the agency and through the Marketplace, in a clear and courteous manner. The criteria outlined below shall be used for communicating with individuals who are blind, deaf, have low literacy; or applicants/beneficiaries who are non-English speaking.
  - Applicant/Beneficiary who is blind
    - Explain the various services offered through the agency and answer any questions asked by the applicant/beneficiary. Read forms in their entirety and assist with completion of forms as needed or requested.
  - Applicant/Beneficiary who is deaf
    - Secure a person proficient in sign language or communicate in writing to explain the programs, answer any questions, and assist in the application process.
  - Applicant/Beneficiary with low literacy
    - Communicate the services offered through the agency in simple terms and phrases that the applicant/beneficiary may easily understand. Assist in the application process.
  - Applicant/Beneficiary with language barriers
    - Secure the assistance of an interpreter capable of speaking the applicant's language to communicate the services offered and assist in the application process by contacting [Language Line Solutions](#).

Expedite the application process upon receipt of the request for urgent medical care.

## **G-300 APPLICATION FORM**

The [BHSF Form 1-A](#) shall be used to review applicants for eligibility; however, if an older version of the application is received, a determination shall be made without requiring the applicant to reapply. Any additional information needed shall be obtained prior to a decision being made.

The applications and documentations required to establish eligibility may come via-

- Online;
  - Applicants may complete an application using the LDH Self-Service Portal that allows the Agency to obtain an electronic signature.
- Telephone;
  - Applicants may complete the application by telephone with a CSU agent. A telephonic signature will be recorded and filed into the case record.
  - Under special circumstances, telephone applications completed by an Agency representative without CSU agent rights using a paper application require the applicant's signature before benefits may be issued. The Agency representative shall mail the signature page to the applicant to sign.
- Mail;
  - Completed, signed applications are accepted by mail. An application is considered incomplete if it does not contain the applicant's name, address, and signature. It is the Agency representative's responsibility to obtain any necessary information on incomplete applications.
- In person; or
- Through other commonly available electronic means.

It is an agency requirement that the applicant sign an initial application under the penalty of perjury. The agency must accept electronic, including telephonically recorded signatures and handwritten signatures submitted via any other electronic transmissions available.

The agency does not require a separate application for Medicaid from an individual automatically entitled to Medicaid following a determination of eligibility by another agency.

The Medicaid application form:

- Is the official agency document used to collect information about the applicant(s) necessary to determine eligibility;

- Is the applicant's formal declaration of financial and other circumstances at the time of application;
- Is the applicant's formal declaration that all information provided is true and correct under the penalty of perjury;
- Provides notice of the applicant's rights and responsibilities
- Shall not be altered after the applicant has signed the form; and
- May be used in a court of law.

## **G-400 TIME LIMITS FOR DISPOSITION OF APPLICATIONS**

Time limits for disposition of applications cover the period from the date of application to the date the agency notifies the applicant of its decision.

Ninety (90) days are allowed for the disposition of applications requesting coverage on the basis of disability, which requires a determination, by the Medical Eligibility Determination Team (MEDT).

Forty-five (45) days are allowed for disposition of all other applications.

For individuals who have applied for LTC Prior to placement in a facility or HCBS and have not received a waiver offer, allow the application to remain pending up to forty-five (45) days. If the applicant is requesting LTC coverage, but has not entered the facility by the 45th day, deny eligibility for LTC and consider eligibility in other programs.

## **G-500 RESERVED**

## **G-510 RESERVED**

## **G-600 WHO MAY APPLY FOR ASSISTANCE**

An individual may apply for medical assistance without delay and may apply for any program they choose.

The following individuals may apply for assistance on behalf of someone else:

- The applicant,

- An adult who is in an applicant's MAGI household (tax filer or non-tax filer),
- An adult who is in the applicant's family, [taxpayer and anyone claimed as tax dependent],
- An Authorized Representative (R-0000):
  - Parent living with a minor child;
  - Legal Spouse;
  - Legal Guardian, curator, or tutor;
  - Power of attorney;
  - Representative for Minor SSI Recipient; or
  - A person designated by applicant to be an Authorized Representative.
- Someone acting responsibly for the applicant who is deceased, a minor or incapacitated per court order. Age and letters from doctors are not evidence of incapacity;
  - Note:**  
A minor may apply for assistance without the consent of the parent or legal guardian with whom they reside.
- The appropriate Office of Juvenile Justice (OJJ) worker for a child in the custody of the state; or
  - Other authorized agencies.

## G-700 APPLICATION DATE

The application date is the date the signed application is received by the Agency, the Federally Funded Marketplace (FFM), an application assistor, or a certified Medicaid application center (AC). This applies to applications taken by telephone or received in-person, mail, fax, or electronically.

Medicaid is responsible for processing all application requests and facilitating the completion of the application.

**G-800 ACCEPTING APPLICATIONS**

The agency shall require a written application, signed under penalty of perjury, on a form issued by the Agency. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission must be accepted.

The Agency must accept an application and any documentation required from:

- The applicant,
- An adult who is an applicant's MAGI household (tax filer or non-tax filer),
- An adult who is in the applicant's family [taxpayer and anyone claimed as tax dependent],
- An Authorized Representative (R-0000):
  - Parent living with a minor child,
  - Legal Spouse,
  - Legal Guardian, curator, or tutor,
  - Power of attorney,
  - Representative for Minor SSI Recipient; or
  - A person designated by applicant to be an Authorized Representative.
- Someone acting responsibly for the applicant who is deceased, a minor or incapacitated per court order. Age and letters from doctors are not evidence of incapacity.

An application will be accepted:

- Via the LDH Self-Service portal;
- By telephone;
- By mail;
- In-person;
- Via the Federal Funded Marketplace (FFM);
- From a certified application center; or
- Through other commonly available electronic means (scanning, imaging, email and facsimile). Requirements to safeguard applicant information apply regardless of mode of submission.

The applicant shall not have the right to remove him or herself from the eligibility process by the act of approving an authorized representative.

The applicant must sign the application unless:

- Deceased, or
- Physically or mentally incompetent or incapable as determined by court order even with an authorized representative.

Refer to ***G-810 Applicant Unable to participate in the Eligibility Determination Process and G-1500 Death of Applicant Before Certification*** for more information on these two situations.

If application is missing a valid signature, the Agency will need to obtain the required signature from the applicant.

Consider the application form properly signed if it contains:

- The applicants name and address; and
- The signature of the applicant/tax filer or the signature of a responsible person if the applicant was unable to sign; or
- The signature of at least one of the parent(s) of the child who resides in the home.

**Note:**

The signature of a minor who chooses to apply, without the consent of the parent or legal guardian, with whom they reside, is acceptable.

**Remote Identity Proofing (RIDP)**

For a real-time eligibility decision to be processed on electronic applications (online or by telephone with a CSU agent), RIDP is processed by the applicant providing answers to personal computer-generated questions to verify identity. If electronic ID proofing is unable to be established or the applicant chooses to skip identity proofing, the Agency representative will have to establish identity of the applicant through electronic system clearances or by requesting verification from applicant.

**Note:**

Paper Applications received by mail or in person do not require electronic ID proofing of the applicant.



**G-810 APPLICANT UNABLE TO PARTICIPATE IN THE ELIGIBILITY DETERMINATION PROCESS**

If the applicant has been determined by court order to be physically incapable or mentally unable to complete the application form and has no one to act on their behalf, complete the form with information received from:

- The parent, spouse, curator, or legal guardian (a person legally responsible for the care and management of the person or property of an individual considered by law to be incompetent to manage his own affairs); or
- The responsible person (a person trusted or depended upon to assist in the care and management of the person or property of an individual, who has not been declared incompetent to manage his/her own affairs);

**Note:**

If the responsible person refuses or fails to cooperate, assist the applicant in designating another responsible person.

- A different friend or relative;
- Any other person with information about the applicant's situation who is designated to act as an authorized representative; or
- By the agency representative's verification and documentation.

**Note:**

If the applicant is unable to participate in the eligibility process, or when the LTC responsible person fails to keep appointments or provide requested information, it becomes the agency representative's responsibility to assist the applicant in completing the application process. When the applicant is unable to participate, obtain and document supervisory approval when assuming this responsibility.

**G-900 APPLICATION INTERVIEWS****G-910 GENERAL INFORMATION**

Interviews are official and confidential discussions of household circumstances. Whenever an interview is conducted, the agency

representative must:

- Inform applicants of their rights and responsibilities;
- Provide information about program policies and procedures;
- Review information on the application form;
- Evaluate all available information, including the existing case record; and
- Explore and resolve any unclear or incomplete information.

In-person interviews shall not be required as part of the application process in determining eligibility.

Appropriate referrals should be made to other agencies based on the needs of the applicant; including referral to the FFM should the applicant not be eligible for Medicaid/LaCHIP.

## **G-911.2 SOURCES OF VERIFICATION**

### **Self-Attestation**

Medicaid eligibility shall not be determined solely on self-declarations except for the below barring any post eligibility conflicting information that may be found:

- Residency;
- Age;
- Household Composition;
- Pregnancy;
- Caretaker Relative;
- Medicare;
- Application for other Benefits; or
- Third party liability (TPL).

#### **Note on Residency:**

Homeless applicants must meet residency requirements but do not deny assistance solely because the assistance unit does not reside at a fixed address or in a permanent dwelling. For this requirement, a home is defined as the family setting maintained by

the relative with whom the child lives as evidenced by the fact that the relative assumes responsibility for the day-to-day care of the child. Assist the homeless family to establish a mailing address that will ensure receipt of their medical eligibility card (MEC) or decision letters. This could be the agency office, a local non-profit agency, or local post office where the beneficiary can pick up the MEC or decision letters.

Self-attested income from the applicant is cleared through the Federal Data Hub and Reasonable Compatibility rules are run to determine if the self-attested income is acceptable or needs to be verified by the applicant.

Any income from Self-Employment that is under program income limits must be verified by the applicant.

Refer to [S-0000 Verification And Documentation](#).

Self-attestation may not be accepted for the following eligibility factors prior to being cleared through the data services Hub and, as a backup, through electronic data sources used by the agency:

- Social Security Number (SSN);
- Citizenship; or
- Immigration status.

**Note:**

If these methods do not verify the self-attestation then self-attestation is accepted for that individual to avoid delays in eligibility. The applicant/beneficiary is then given a reasonable opportunity period to obtain satisfactory evidence for the individual before taking adverse action on the individual's eligibility.

See [I-352 Reasonable Opportunity to Present Satisfactory Documentary Proof of Citizenship](#) and [I-600 Enumeration](#).

Verify any questionable information that affects eligibility. Sources may include available data sources, collateral contacts, copies of paid or unpaid medical bills, contacts with former employers or absent parents, or any other source that can verify the applicant/beneficiary's situation.

Only require the applicant to provide information that cannot be obtained from other data sources and is necessary to make an eligibility determination. Give the applicant/beneficiary written notice of the specific verifications required and the date the information is due. Allow at least

ten (10) calendar days for an applicant/beneficiary to provide the requested verifications.

**Exception:**

Allow at least thirty (30) calendar days for a beneficiary to provide the requested verifications needed for a renewal of eligibility based upon MAGI methodology.

**G-911.3 CASE RECORD DOCUMENTATION REQUIREMENTS**

Document in the case record how any questionable information was verified.

**G-911.4 CASE ACTION**

Do not deny benefits because applicant/beneficiary gives questionable or inconsistent information, unless defined as refusal to cooperate. Deny benefits or close the case when the applicant/beneficiary fails to provide verification or refuses to cooperate in providing verification. Refer to ***G-1100 Cooperation thru G-1140 Failure to Cooperate*** for exceptions.

**G-920 INTERVIEWS**

A face-to-face interview is not required. A telephone interview is allowed.

Refer to **G-800 Who May Apply for Assistance**. If a long-term care interview cannot be conducted, refer to ***G-810 Applicant Unable to Participate in the Eligibility Process***.

**G-930 INTERVIEW SITES**

If the applicant/beneficiary requests a face-to-face interview, conduct it at an LDH office or an application center, if possible.

If not possible, conduct the interview at a site that is adequate to preserve the privacy and confidentiality of the interview, and convenient to both the applicant and the agency representative.

Adequate sites may include a hospital or a LTC facility.

**G-940 REQUIRED INTERVIEW EXPLANATIONS**

The agency requires all initial applications to be signed by the applicant under penalty of perjury.

During the application interview, explain the following in terms that the applicant can understand:

- The applicant's responsibility to provide information that is true and correct to the best of their knowledge;
- The applicant's responsibility to cooperate in the eligibility determination process;
- The applicant's responsibility to report all changes that may affect eligibility;
- The legal penalties for withholding information or providing false information;
- That the applicant's SSN will be matched against files of the Social Security Administration (SSA);
- The agency's confidentiality policy;
- The agency's nondiscrimination and equal delivery of services policy;
- The applicant's right to an agency conference or a fair hearing;
- Assignment of rights to medical support and third party resources, and
- Estate Recovery.

**NOTE:**

The National Voter Registration Act of 1993 (NVRA) requires the Agency to offer the applicant/beneficiary the opportunity to register to vote when applying for benefits, renewing benefits, or changing their address and/or name.

During the application interview, the following information must be furnished to all applicants and other individuals who request it:

- The eligibility requirements;
- Available Medicaid Services; and
- The rights and responsibilities of applicants and beneficiaries.

**G-1000 SECURING INFORMATION TO DETERMINE ELIGIBILITY**

Secure essential information for determining eligibility. Only require the applicant to provide information that cannot be obtained from other data sources, or the information obtained electronically is not reasonably compatible, and is necessary to make an eligibility determination or for purposes directly connected to the administration of the Medicaid State Plan.

The agency shall not request verification for information sent to the agency by the FFM that has been verified.

Consider the applicant as the primary source of information. The act of designating an authorized representative does not change or diminish the applicant/beneficiary's responsibility to provide complete and correct information on the application form.

The applicant/beneficiary/responsible person or authorized representative is required to:

- Make an effort to obtain all information needed to determine eligibility;
- Authorize the obtaining of documents from third parties;
- Answer all eligibility related questions to the best of their knowledge; and
- Report any changes that may affect eligibility.

If the applicant cannot furnish all of the required verifications at the time of application:

- Send a request for information (RI) that contains a list of the items or actions needed with the deadline for submission specified. Allow at least ten (10) calendar days for an applicant/beneficiary to provide the requested verifications.

**Exception:**

Allow at least thirty (30) calendar days for a beneficiary to provide the requested verifications for a renewal.

If the applicant is unable to obtain the needed information, provide assistance by:

- Review of the EDMS;
- Checking electronic data sources;
- Use of consent forms signed by the applicant to request verification directly from collateral sources; and
- Requesting assistance from other Medicaid regions and State agencies in order to secure court records and other pertinent data.

In situations involving a life-threatening health condition requiring urgent medical care, the Medicaid analyst shall expedite the application process, taking special steps to obtain any required verifications, including a field visit, if necessary.

## **G-1100 COOPERATION**

The agency representative has a responsibility to decide whether an applicant is capable of participating in the eligibility process. Refer to ***G-810 Applicant Unable to Participate in the Eligibility Determination Process***.

For all applicants incapable of cooperation due to a physical, mental or intellectual condition, the application shall not be rejected for failure to cooperate.

## **G-1110 COOPERATION BY PHYSICALLY AND MENTALLY ABLE APPLICANTS**

The applicant must cooperate in the process of determining eligibility by completing an application form, being interviewed (when necessary), and providing required information. Refer to ***G-1130 LTC Refusal To Cooperate***.

The agency representative shall:

- Allow adequate time for the applicant/beneficiary to receive notice of the interview and make arrangements to attend;
- Inform the applicant in writing of what is required and the consequences of not cooperating;
- Allow at least ten (10) calendar days for the applicant to provide the information or advise the agency representative that the requested

information cannot be secured; and

- Assist the applicant in obtaining the needed information or identify and secure alternate information.

The applicant/beneficiary shall not be asked to provide information that is clearly impossible for them to secure. Only require the applicant/beneficiary to provide information that cannot be obtained from other data sources and is necessary to make an eligibility determination.

### **G-1120 COOPERATION BY LTC AND OTHER APPLICANTS UNABLE TO PARTICIPATE**

For applicants unable to participate in the eligibility determination process, refer to ***G-810 Applicant Unable to Participate in the Eligibility Determination Process***.

### **G-1130 LTC REFUSAL TO COOPERATE**

The application may be rejected only if the applicant, parent, or legal guardian:

- Is physically, mentally, or intellectually able to apply and provide information;
- Has been notified of the need to provide information;
- Has been advised of the consequences of not cooperating; and
- Has refused to do so.

Do not reject an application for refusal to cooperate if the responsible person refuses to cooperate. In this case, assist the applicant in designating another responsible person. If none can be located, refer to ***G-810 Applicant Unable to Participate in the Eligibility Determination Process*** or ***G-1120 Cooperation by LTC and Other Applicants Unable to Participate***.

### **G-1140 FAILURE TO COOPERATE**

It is the agency's responsibility to pursue the eligibility determination through the decision, unless the applicant/beneficiary refuses to



cooperate. Refer to ***G-1130 LTC Refusal to Cooperate***.

Before denying or closing eligibility for failure to cooperate, review the case record to determine the following:

- That the applicant/beneficiary/responsible person is physically, mentally, or intellectually able to meet responsibilities;
- That adequate time was given to provide the information or evidence;
- That the applicant/beneficiary was given enough notice to make arrangements to provide the information requested or has made contact asking for a specified future date to provide;
- That the request for information was clear, in writing, and dated;
- That the applicant/beneficiary/responsible person was informed of the responsibility for providing and consequences of not providing information; and
- That the applicant/beneficiary is not claiming good cause for failure to cooperate in pursuing a responsible third party. Refer to [\*I-200 Assignment of Rights\*](#).

## **G-1150 SECOND CONTACT SITUATIONS**

Second contacts are required in the following situations:

A patient in an acute care hospital is given ten (10) calendar days to provide requested information. If the information is not provided, a final notice is sent to the applicant with an additional ten (10) calendar days given to supply the requested information. If the information is not received, the application cannot be rejected until the 45th calendar day for MAGI categories or the 60th calendar day for Non-MAGI categories.

If the agency representative is unable to judge the applicant's capability, contact the applicant or responsible person prior to rejecting the application for:

- Failure to cooperate in supplying requested data;
- Refusal to comply with agency regulations; or
- Failure to keep an appointment without contacting to reschedule.

After the second contact, if the applicant or responsible person fails to

comply with the above, reject the application the day after the date of noncompliance.

**G-1200      *RESERVED***

**G-1300      **OBVIOUS INELIGIBILITY****

Reject the application at any point during the eligibility determination when there is enough information obtained and recorded to establish ineligibility. See [S-0000 Verification and Documentation](#).

- If enough information is provided on the application form or in the interview that establishes that not all eligibility factors are met, explain that the application will be rejected without any further investigation.
- If the information is received after the initial interview, contact the applicant to establish that the information is correct. If correct, explain that the application will be rejected and send the appropriate notice of rejection.

**NOTE:**

Advise the applicant that the case is being referred to the FFM for enrollment in an IAP.

**G-1400      **WITHDRAWALS****

Withdrawals are initiated by the applicant/beneficiary.

An applicant may voluntarily withdraw the application or request closure of their case at any point in the eligibility process.

The applicant is allowed to request withdrawal verbally or in writing. Document the case record with the reason for withdrawal denial or closure and send the appropriate notice.

**G-1500      **DEATH OF APPLICANT BEFORE CERTIFICATION****

If an applicant dies before certification and eligibility is established, certify the case. Eligibility cannot extend beyond the date of death.

An eligibility determination may be made even if the applicant dies before signing the application form. Refer to **MEM G-600 Who May Apply for Assistance**. If there is no one to act for the deceased applicant, complete the application form with information received:

- From a person who is knowledgeable of the decedent's circumstances and can report the required information for eligibility determination accurately and under penalty of perjury; or
- By agency representative verification and documentation. The agency representative shall obtain sufficient evidence to support the decision.

**Note:**

Long Term Care and medical providers shall not be allowed to sign the application form.

A disability decision is required for deceased applicants for the period of assistance requested, if the application is in the disability-related non-MAGI category (Category D) and the applicant did not receive a Social Security (SSA) disability determination.

## **G-1600      SECURING DISABILITY DECISIONS FOR NON-MAGI (FORMERLY B AND D) CATEGORIES**

Refer to *E-220 Blind (B)* and *E-240 Disabled (D)* and *I-2100 Supplemental Security Income (SSI) Eligibility Status*.

If the applicant has not already been determined disabled by SSA, submit the Medical Eligibility Determinations Team (MEDT) package.

## **G-1610      DISABILITY DECISIONS**

Louisiana Medicaid's MEDT determines categorical eligibility for disability/blindness based on medical criteria established by the SSA under Section 1634 of the Social Security Act. An SSA disability decision takes precedence over any contrary state disability determination. An MEDT decision should not be requested when the individual receives SSA disability, SSI benefits, or Medicare.

A disability decision shall not be requested from MEDT if the individual is otherwise ineligible. Send the appropriate denial notice and refer the

applicant's case to the FFM for review for enrollment in an IAP.

All Medicaid applications or renewals based on disability, including those for nursing facilities or waiver services programs, require submission of a complete MEDT package, unless there is an existing MEDT approval that covers the certification period. For more information, refer to the [Form MS Instructions](#).

The Medicaid analyst is expected to assist to obtain any required medical documentation for the package. In situations involving life-threatening health conditions requiring urgent care, expedite the application process.

### **G-1610.1 MEDT PACKAGE**

The MEDT Package consists of:

- The request for an MEDT decision from an MEDT consultant which contains the applicable program type, specific notes on case the consultant would need to know, and the period of coverage requested;
- Completed Social information Interview form ([Form MS](#)), for all adult decisions, or a Minor Child's Medical and Social information form ([Form MS/C](#)), if a minor;
- Medical records obtained from providers;
- All previous MEDT decisions and supporting documentation.

### **G-1610.2 MEDT DECISION REQUIRED**

An MEDT decision is required if:

- A disability decision has not been rendered by SSA;
- SSA has rendered an unfavorable disability decision and:
  - Medical documentation is available to demonstrate the deterioration of the applicant's medical condition since the SSA denial;
  - A new medical condition can be documented;
  - The applicant is appealing the SSA determination; or
  - The applicant is employed and applying for Medicaid Purchase Plan coverage;

- Retroactive eligibility is requested; or
- The applicant has been diagnosed as, or is suspected of being, infected with tuberculosis and is not eligible in a non-MAGI category (formerly category A, B, or D).

### **G-1610.3 MEDT DECISION NOT REQUIRED**

An MEDT decision is not required if:

- A favorable SSA decision has been rendered for disability or Medicare which covers the requested period of Medicaid eligibility;
- The applicant is otherwise ineligible; or
- The applicant has lost RSDI/SSI for a reason other than cessation of disability, and a favorable SSA disability decision has been made within the twelve (12) months prior to application.

### **G-1610.4 MEDT APPROVAL**

If the applicant is otherwise eligible. Authorize the case.

If a case has closed and later recertified, the MEDT decision remains in effect, unless there has been improvement in the beneficiary's condition. Submit a new MEDT packet prior to the MEDT due date if there has been improvement in the beneficiary's condition.

A subsequent adverse disability decision made by SSA/SSI, that is not timely appealed, takes precedence over the MEDT consultant decision.

**Exception:**

Submit a new MEDT packet for re-evaluation of the agency's disability determination if a subsequent adverse disability decision by SSA is made for an MPP beneficiary.

### **G-1610.5 MEDT DENIAL**

Reject the application or close the case upon receipt of the MEDT denial decision. If applicable, issue an advance notice of closure.

**G-1610.6 RECONSIDERATION OF MEDT DENIAL**

A request for reconsideration of the MEDT decision should be completed if:

- New medical or social information is obtained; or
- At appeal, additional medical documentation is available which supports the deterioration of the applicant/beneficiary's condition; or
- A new medical condition can be documented.

**G-1610.7 RESUBMIT TO MEDT**

Resubmit a complete MEDT package:

- If the MEDT decision does not include the needed period of coverage, i.e., retroactive;
- For a different categorical decision requiring MEDT approval;
- At renewal;
- At renewal for a beneficiary who lost RSDI/SSI for a reason other than cessation of disability;
- At renewal for a case certified or continued based on a Division of Administrative Law decision;
- If there are changes in the case which require approval by MEDT for continuance; or
- If a subsequent adverse disability decision is made by SSA/SSI for an MPP beneficiary.

**Exception:**

Do not resubmit to MEDT if the SSA Denial code is N07, N08, N15, N16, N30, N35, N40, N41, N44, N46 or N51.

**Note:**

Verbal MEDT approval will not be provided.

**G-1610.8 REAPPLICATION AFTER MEDT DENIAL**

If the applicant reapplies within ninety (90) days from the date of a previous MEDT denial, reject the Medicaid application unless there has been a significant deterioration of the applicant's medical condition or a

new medical condition is documented.

Include the applicant's statement regarding the change in their medical condition since the last MEDT denial on the Form MS or MS/C.

### **G-1610.9 REQUESTING AUTHORIZATION FOR MEDICAL EXAM**

The analyst should first determine if medical documentation is available from a licensed physician, clinic, hospital, Disability Determination Services (DDS), Louisiana Rehabilitation Services (LRS), or other sources. If medical documentation is not available for an MEDT decision, a request for authorization of a medical exam shall be included on the request sent to the MEDT consultant.

**Note:**

A completed Form MS is required with the submittal.

If authorization is approved, the analyst shall request a written report from the physician regarding the applicant's medical condition. In accordance with instructions, Form [MR-A](#) shall be used to authorize payment for the examination. The written report shall be included as part of the complete MEDT packet.

### **G-1610.10 SSA CERTIFIES APPLICANT FOR SSI**

Upon receipt of documentation that SSA has certified the applicant for SSI:

- Certify for Medicaid (manually or through the State Data Exchange (SDX) process);
- Certify for LTC retroactively to the date of SSI eligibility if the applicant was a resident of an LTC facility and met all of the other eligibility factors (Refer to [H-800 Long Term Care](#)); and
- Make appropriate case changes, if the case was certified based on the MEDT Consultant approval.

### **G-1610.11 SSA DENIALS**

If SSA has denied the applicant's/beneficiary's SSI application based on disability in the last twelve (12) months and the applicant is not appealing

the SSA denial, reject the application or initiate closure action if the case was certified based on the MEDT Consultant approval. Refer to [L-0000 Changes](#).

**Exception:**

Submit or re-submit a MEDT packet for MPP disability determination if the applicant/beneficiary is employed.

## **G-1610.12 SSI APPEALS**

### **Pending Application Disability-Related Medicaid**

Request an MEDT decision if SSA has denied the application based on disability in the last twelve (12) months and the applicant provides documentation that the SSA determination has been timely appealed. Submit or re-submit an MEDT packet for program type MPP disability determination if the applicant/beneficiary is employed.

### **Certified Disability-Related Medicaid Case**

If an individual receiving Medicaid based upon disability is determined by SSA not to be disabled under the SSI standard and the individual provides documentation that the SSA determination has been timely appealed, continue Medicaid coverage when all other eligibility factors are met until the final determination of disability has been made by SSA. Review available interfaces or contact the local SSA office requesting notice of appeal decision.

Follow-up with SSA is required every ninety (90) days.

## **G-1610.13 SIGNIFICANT DETERIORATION IN MEDICAL CONDITION AFTER SSA DENIAL**

If the applicant has been denied based on disability within the twelve (12) months prior to the Medicaid application, reject the Medicaid application unless:

- An SSI appeal is in progress and the applicant's income is above the Federal Benefit Rate (FBR);
- A significant deterioration in medical condition can be documented;
- A new medical condition can be documented; or
- The applicant is employed and is applying for MPP coverage.



Include the applicant's statement regarding the change in medical condition since the denial on the Form MS or MS/C. Give the applicant ten (10) days to provide additional documentation verifying the change in medical condition before submitting the request to the MEDT consultant.

**G-1615      *RESERVED***

**G-1620      **SIMPLIFIED DISABILITY DECISIONS FOR INFANTS****

Louisiana Medicaid allows a simplified determination of disability based on minimal evidence for premature or low birth weight infants and/or those infants with an allegation or diagnosis of Down syndrome, even if no other medical impairments exist.

A simplified disability decision for infants always begins on the date of birth and extends until the child reaches the age of one (1) year (date of birth through the 12th month).

Continuing eligibility for Medicaid must be explored whenever there are changes in the child's circumstances that affect eligibility or once the simplified disability period ends. Another MEDT decision is required for an ongoing disability decision. A review of all current medical evidence must be completed.

**G-1620.1      **MEDT PACKAGE****

MEDT will make the simplified disability decision for infants. Submit a MEDT package consisting of a current request for MEDT decision from the MEDT Consultant requesting a simplified disability decision with a birth certificate or other evidence (e.g., the hospital admission summary, physician or other medical professional's statement) that shows:

1. A weight below 1,200 grams (2 pounds, 10 ounces) at birth; or
2. A gestational age (age from conception to birth) at birth as specified in the bulleted list below with the corresponding birth weight indicated:
  - If the gestational age is 37- 40 weeks and the weight at birth is less than 2,000 grams (4 pounds, 6 ounces);
  - If the gestational age is 36 weeks and the weight at birth is less

- than 1,875 grams (4 pounds, 2 ounces);
  - If the gestational age is 35 weeks and the weight at birth is less than 1,700 grams (3 pounds, 12 ounces);
  - If the gestational age is 34 weeks and the weight at birth is less than 1,500 grams (3 pounds, 5 ounces);
  - If the gestational age is 33 weeks and the weight at birth is at least 1,200 grams, but no more than 1,325 grams (2 pounds, 15 ounces); or
3. An allegation or diagnosis of Down syndrome.

## **G-1700 RE-USING THE APPLICATION FORM**

An application form may be reused to open a new application only in the following situations:

- To reopen an application rejected in error; or
- To reopen an application that was denied for failure to return documentation, when needed documentation is returned within 30 days; or
- To reopen a Spend-Down MNP case when there is no break in quarters of coverage.

### **Applications Rejected in Error**

Use the previous application date as the date of application when reopening an application rejected in error, or upon reconsideration resulting from an appeal request.

Contact the applicant if additional information is needed to determine eligibility. If additional information is required, allow the applicant time to return the information.

### **Applications That Were Denied**

Use the previous application date as the date of application when needed documentation is received within 30 days of the mail date of the decision notice.

### **Spend-Down Medically Needy Program (SD-MNP)**

The [BHSF Form 1-A](#) used in making a determination for SD-MNP is valid

for up to twelve (12) months from the date of application as long as there is no break in quarters of coverage. Refer to [H-1011 MNP Groups](#) for more information on SD-MNP.

### **Re-using the Renewal Form**

For individuals whose eligibility was terminated at renewal for failure to return the renewal form or needed documentation, the agency must reconsider eligibility without requiring a new application if the renewal form and/or requested information is returned within 90 calendar days after the date of termination.

The renewal form returned within the reconsideration period serves as an application, which means the agency must make a determination consistent with application timeliness standards.

The effective date of coverage for individuals found eligible for Medicaid will be the 1st day of the month the renewal was returned. Up to 3 months of retroactive coverage is available if the individual received Medicaid services following their termination and meet the Medicaid eligibility requirements when services were received.

### **G-1800      *RESERVED***

### **G-1900      REFERRALS TO SSI**

An application for SSI is not a requirement for eligibility in any Medicaid Program.

If the applicant/beneficiary applies for SSI, the Agency will be notified by SDX of SSI certification or denial.

### **Scenarios for general Medicaid applications**

See [Z-400 Federal Benefit Rate](#) for FBR amounts

Individuals with/without spouse	Income and resources below FBR. Referral for SSI is required.
Individuals with/without spouse	Income below FBR but resources above SSI resource limit. Ineligible for SSI and

Medicaid. Do not refer to SSI.

Couple

If both members of a couple are applying and their countable couple income falls below couple FBR and couple resource limit. Referral for SSI is required.

**Scenarios for LTC Medicaid applications**

See [Z-400 Federal Benefit Rate](#) for FBR amounts

LTC applicant w/o  
community spouse

Applicant's income and resources below FBR. Referral for SSI is required.

LTC applicant w/o  
community spouse

Applicant's income below individual FBR, but resources exceed individual limit. Do not refer to SSI.

LTC applicant  
w/community spouse

Applicant's income below individual FBR. Resources in applicant's name exceed SSI individual limit and/or countable couple resources exceed the individual resource limit. Do not refer for SSI. Explain the spousal impoverishment resource provisions and the allowance under Medicaid LTC Program for transfers to the community spouse. Referral for SSI may be appropriate at renewal.

LTC applicant  
w/community spouse

Applicant's income below individual FBR and countable couple resources below individual SSI resource limit. Referral for SSI required.

LTC Couple

If both members of a couple are applying, consider income eligibility separately as individuals. If either has income below individual FBR, refer only that member for SSI.

## Scenarios for HCBS Medicaid applications

See [Z-400 Federal Benefit Rate](#) for FBR amounts

HCBS applicant, no spouse	Income and resources below individual FBR. Referral for SSI required.
HCBS applicant, no spouse	Income below individual FBR, but resources exceed limit. Do not refer for SSI.
HCBS applicant w/spouse	Applicant's income (including deemed income from ineligible spouse) and resources fall below individual FBR. Referral for SSI required.
HCBS applicant w/spouse	Income is below FBR, but resources exceed individual limit. Do not refer for SSI. Explain the spousal impoverishment resource provision and the allowance under Medicaid LTC/HCBS programs for transfers to the community spouse.

## G-2000 DECISION NOTICES

Send the eligibility decision notice to the applicant upon disposition of the application.

For limited certifications (e.g., deceased applicant, complete retroactive certifications, and SD-MNP), the notice of certification may also serve as the closure notice.

The agency must provide individuals with the choice to receive notices and information in electronic format or by regular mail.

When an applicant/beneficiary is determined ineligible using the MAGI income methodology and the applicant/beneficiary is not aged, blind, or disabled, a notice shall be sent advising the applicant/beneficiary of the decision and advising them that their application is being referred to the Marketplace.

**LTC Only**

Send a notice of the eligibility decision to the applicant/authorized representative and the LTC facility.

**HCBS Only**

Send a notice of eligibility decision to the applicant, the HCBS provider, and the LDH Office for Citizens with Developmental Disabilities (OCDD) or LDH Office of Aging and Adult Services (OAAS), as applicable.

**G-2100 RETROACTIVE REIMBURSEMENT**

The agency reimburses the Medicaid beneficiary for part or all of any medical expenses paid by them from the effective date of eligibility through the date that they are expected to receive their MEC or the reactivation of the MEC.

Beneficiaries are eligible for reimbursement of medical expenses paid up to three (3) months prior to the month of application only if they request retroactive eligibility on their application and they are certified for the months requested. [Refer to H-1800 Retroactive Medical Eligibility.](#)