N-0000 SPECIAL PROCESSING

N-150 thru 160 RESERVED

N-200 LOCK-IN

N-210 DEFINITION

Lock-In is a mechanism for educating Medicaid enrollees regarding physician and pharmacy Medicaid benefits. It provides a means for physicians and/or pharmacy providers to monitor an enrollee's utilization of services.

Enrollees are restricted to services from:

- A primary care physician;
- Specialists (if needed);
- One pharmacy provider; and
- Specialty pharmacy (if needed).

The enrollee is not prohibited from receiving services other than physician and pharmacy services.

The Lock-In Program:

- Ensures appropriate use of Medicaid benefits by enrollees and/or providers; and
- Serves as an educational device in instructing enrollees in the most efficient method of using Medicaid services to ensure maximum health benefits.

N-220 EXCLUSIONS

The following services are specifically excluded from the Lock-In Program:

Emergency Services

An enrollee shall not be denied emergency physician or pharmacy services routinely covered, within program regulations.

Referral by Lock-In Physician

Reimbursement may be made within program regulations to another physician for services provided to an enrollee with a referral from the Lock-In physician (or the Lock-In specialist) on record.

N-230 WHO MAY BE PLACED IN LOCK-IN

Any enrollee may be placed in the Lock-In Program who:

- Is eligible for Medicaid benefits; and
- Has shown a consistent pattern of overuse or unwise use of program benefits.

N-240 LDH RESPONSIBILITIES IN PLACING THE ENROLLEE IN LOCK-IN

Identification

Potential Lock-In enrollees are identified by the Bureau of Health Services Financing (BHSF) Pharmacy Benefits Section, the Surveillance Utilization Review (SUR) department (operated by Molina Medicaid Solutions in partnership with the Louisiana Department of Health (LDH), Office of Program Integrity), concerned providers, or concerned citizens. The decision to lock a particular enrollee into the program shall rest with the Pharmacy Benefits Section.

Notification to the Lock-In Unit (University of Louisiana at Monroe (ULM))

Pharmacy Benefits pharmacists make the decision to enroll an enrollee in the Lock-In Program. BHSF or its representative shall forward a notification to the Lock-In Coordinator of the decision to enroll an enrollee in the Lock-In Program.

Other Notification

The agency representative contacts the enrollee's choice of providers, to determine if the provider will accept the enrollee as a patient in the Lock-In program, before submitting the request to the Lock-In Unit.

N-241 BHSF RESPONSIBILITIES IN PLACING THE ENROLLEE IN LOCK-IN

Explanation of Lock-In Mechanism to the Enrollee

Upon receipt of notification from LDH, the Lock-In Coordinator shall initiate the Notification of Lock-In Initial Form giving the enrollee timely notice. If the decision is appealed, the Pharmacy Benefits Section in LDH's state office is responsible for the summary of evidence and will attend the fair hearing.

The Notification of Lock-In Initial Form shall state clearly:

- LDH's decision to allow the enrollee to choose one pharmacy provider and specialty pharmacy provider (if needed) and/or one physician provider and up to three specialists (if needed);
- That LDH will not make payments to providers other than the ones chosen;
- An agency representative initiates contact with the enrollee to make arrangements to choose the allowed providers;
- The enrollee is being placed in Lock-In status because of LDH's concern about his ability to use medical benefits in a way most beneficial to his well-being;
- The enrollee will be prohibited from choosing a physician who has been identified by LDH as an over-prescriber;
- The enrollee may choose more than one provider of physician services if a specialist is required; and
- The enrollee may appeal the Lock-In decision.

Completion of the Lock-In Provider Request Form

The Lock-In Provider Request Form is used to request providers at initial contact and at each subsequent contact when a change or addition in physician or pharmacy is:

- Requested by the enrollee;
- Requested by the Lock-In provider; or
- Required by LDH.

The enrollee may choose providers. They may choose one (1) primary care

physician and up to three (3) specialists (if needed), and/or one pharmacy and specialty pharmacy (if needed).

Forward the Lock-In Provider Request Form to LDH via fiscal intermediary, Attention: Lock-In Program. The initial notification shall inform LDH that the enrollee has chosen his providers. LDH will give approval or disapproval of the enrollee's choice of providers and the effective date of Lock-In.

If LDH disapproves the enrollee's choices, the Lock-In Coordinator contacts the enrollee and advises them that a new choice for physician and/or pharmacy provider is required.

If the enrollee refuses to choose providers, LDH may suppress the enrollee's physician and/or pharmacy benefits until they choose. The enrollee will be notified by the Lock-In Coordinator.

Medical Eligibility Card (MEC)

When an enrollee is placed in the Lock-In program they are not issued a new medical eligibility card. The enrollee's regular medical eligibility card is used. Once the provider information is approved by LDH Pharmacy Benefits Section, it is added to the enrollee's Medicaid Management Information System (MMIS) file. This information then transfers to the Medicaid Eligibility Verification System (MEVS) and Recipient Eligibility Verification System (REVS) files, which providers use to verify eligibility and Lock-In provider names.

Requests to Change Providers

Enrollees may change Lock-In providers every year without cause. When there is a "good cause" reason, enrollees may change Lock-In providers with LDH or the agency representative's approval.

Enrollees may change providers for the following "good cause" reasons:

- The enrollee relocates;
- The enrollee's primary diagnosis changes, requiring a different specialist;
- The Lock-In provider requests that the enrollee be transferred; or
- The Lock-In provider stops participating in the Medicaid Program.

When an enrollee requests to change their Lock-In provider, the Lock-In Coordinator asks the enrollee the reason the change is requested. The reason should be noted. If the change is for a physician provider, the

Lock-In Coordinator contacts the current Lock-In physician to verify:

- The last date the enrollee was provided a service by the provider; and
- The enrollee's reason for requesting a change (e.g., death or retirement of the treating physician, treating physician no longer wishes to accept Medicaid enrollee).

Requests to change providers are forwarded to the attention of the fiscal intermediary.

When provider information is changed or added to the MMIS file, the information transfers to MEVS and REVS files.

Follow-Up

In rare situations, LDH may request the agency representative to follow-up on cases in which there appears to be continued misuse of the Medicaid program. Upon receipt of such a request, the agency representative shall contact the enrollee and:

- Emphasize the importance of proper use of benefits; and
- Advise him/her that possible referrals to other agencies may be made.

The agency representative shall not have responsibility to investigate for fraud or possible criminal activity.

Action Following Closure or Discontinuance

An enrollee shall remain in Lock-In status when:

- Recertification of Medicaid only assistance occurs in less than four (4) months after closure; or
- The case is discontinued for TANF cash but the enrollee remains Medicaid eligible.

N-300 MANDATORY STATE SUPPLEMENT (MSS)

N-310 GENERAL INFORMATION

Prior to January 1974, cash benefits to persons who were aged, blind, or disabled were provided by individual states. After that date, the federal government took over eligibility determination and payment to

the aged, blind, and disabled under the Supplemental Security Income (SSI) program.

States were required to provide a supplemental payment to former enrollees of these aged (A), blind (B), or disabled (D) programs who had a higher state payment in December 1973 (because of budgeted special needs) than the standard SSI payment effective January 1974, after conversion.

In Louisiana, these supplemental payments are called MSS. This payment is made entirely from state funds, but is included in the SSI check.

Although the MSS program is federally administered, Louisiana is required to maintain the income of former recipients of these aged, blind, and disabled programs at the December 1973 income level, plus subsequent cost of living adjustments.

The Social Security Administration (SSA) maintains the records, determines eligibility, and issues the MSS checks, but the state must provide information to SSA regarding changes in special needs or circumstances so that the eligibility determination will be current. SSA will continue or decrease the MSS payment based on these changes. MSS payments cannot increase (once reduced) because of decreased special needs, or begin again once closed.

An MSS enrollee is eligible for consideration for a payment until the individual:

- Dies;
- No longer meets the age, blindness or disability definitions for SSI; or
- No longer has the special need upon which MSS is based.

An individual can lose and later regain the MSS payment only because of changes in income.

N-320 MINIMUM INCOME LEVEL (MIL)

The Minimum Income Level (MIL) is the standard used to determine the amount of MSS. A MIL was established for each converted recipient at the amount equal to his December 1973 income, including welfare payment.

Enrollees cannot have their MSS payments reduced or terminated

solely because of Cost-of-Living (COLA) increases in SSI or Retirement, Survivors and Disability Insurance (RSDI). In order to prevent the loss of MSS because of COLAs, the MIL is increased by the same percentage as the COLA, each time there is a COLA.

The SSA will automatically increase the MIL, calculate the MSS payment and transmit it to the state via State Data Exchange (SDX) through the SDX system.

SSA determines the MIL based on the December 1973 grant amount and countable income using the following formula:

December 1973 grant amount
\+ December 1973 other income
\+ SSI annual COLA percentage increases ("pass alongs")
\- 20.00 SSI standard deduction
MIL

N-330 RESERVED

N-340 SPECIAL NEEDS

Special Needs are those other than the basic needs of food, clothing, and utilities which were included in cases converted to SSI.

Special needs which were allowed in the budget in December 1973 are:

- Essential person;
- Housekeeping services;
- Room and board and change in living arrangements;
- Shelter;
- Special care; and
- Transportation and dependent care.

In no instance may a special need be added or increased. Once reduced or terminated, a special need cannot be regained.

Review special need annually.

N-340.1 Essential Person

An essential person is a spouse or other individual under age 65:

- Whose needs were taken into account and included in the certification of an eligible individual for a money payment;
- Who was or should have been converted to SSI in January 1974;
- Who continues to live in the home of the eligible individual;
- Who is not eligible in his or her own right or as the eligible spouse of the eligible individual or any other individual; and
- Who does not have income or resources in an amount that causes the eligible individual to lose eligibility for SSI.

An allowance for an essential person may not be reduced. The allowance shall be removed for the month after the change or request for the following reasons:

- At the eligible individual's written request;
- The essential person was incorrectly included in the 1973 conversion budget;
- The death of the essential person;
- If the eligible individual leaves the essential person with no intention of returning or the probability of returning is remote;
- The essential person leaves the household for more than ninety (90) days or for less than ninety (90) days if the move is permanent;
- The eligible individual leaves the essential person for six months or more;
- The essential person reaches age 65;
- The essential person is certified for SSI or Family Independence Temporary Assistance Program (FITAP); or
- If the income or resources deemed from the essential person make the recipient ineligible.

Note:
Remove the essential person allowance effective the month after the change or request. If there is an increase in the essential person's income or resources, report the increase

to SSA on Form 1610. SSA will take action to stop or to reduce the MSS payment.

A converted case should not have had an allowance for both an essential person and special care needs. If this has occurred, report to SSA on Form 8220 which special care needs should not have been included at conversion.

Refer any essential person to SSI if age or health indicates potential eligibility.

N-340.2 Housekeeping Services

Housekeeping services are routine tasks for the upkeep of the home that are performed by someone outside the household.

Budget allowances for housekeeping services as allowed in December 1973 only if they have been provided continuously since December 1973.

N-340.3 Room and Board/Change in Living Arrangement

If a recipient has changed living arrangements, the special need allowance for shelter and/or room and board shall be reviewed for continuation, reduction or removal.

Note:
An amount previously allowed for shelter cannot now be counted as a cost of room and board nor can the room and board cost be changed to cover shelter when living arrangements change.

N-340.4 Shelter

Shelter includes mortgage payments and home repair costs that were budgeted for December 1973. This special need is for the mortgage or home repair costs budgeted in that month, and cannot be continued if the payment period has expired. The payment period was determined at conversion and is documented in the case record of the Department of Child and Family Services Child Welfare Division (CWD). Review home repair costs carefully because it is unlikely that such costs budgeted in December 1973 are still being paid.

Note:
Remove this special need expense if the payment period has expired. Do not budget mortgage or home repair costs incurred since December 1973.

N-340.5 Special Care Needs

Special care needs are services provided to a recipient by someone outside his household because the enrollee requires assistance with his personal needs, such as eating, bathing, dressing, getting about in his home, keeping house and shopping.

Continuous receipt of special care should be documented. This need should be removed if services have not been received on a continuing basis since December 1973.

N-340.6 Transportation and Dependent Care

Allowances for transportation and dependent care shall be removed if still budgeted because:

- Transportation for medical services is provided by the Medicaid program; and
- All dependents included in December 1973 have now reached age 18.

N-350 COMPUTING THE SPECIAL NEEDS BUDGET

Verify current SSI eligibility. Review the December 1973 budget form in the case and determine, for that month, the cost of any of the following special needs that were included:

- Essential person;
- Housekeeping services;
- Room and board and living arrangements;
- Shelter;
- Special care; or
- Transportation and dependent care.

Verify that the 1973 special need is still required and being received.

Verify the cost of each special need that is still required and work a new budget using the budget form.

If there has been a reduction in the cost of a special need or if a special need is no longer required or no longer provided, work a new budget using the December 1973 budget form:

- Using the same budgeting procedures that were used for the December 1973 budget; and
- Using the current cost of the special need, subject to the actual amount budgeted in December 1973, not to exceed the December 1973, program limits. Refer to Z-1100 Maximum Grants for MMS Categories A, B, and D Prior to Conversion to SSI.

Do not budget an increase in the special needs.

Subtract the new grant amount from the December 1973 grant amount.

The difference between the two grant amounts is the Special Needs Reduction to be reported to SSA.

If there is no difference between the two grant amounts, there is no special needs reduction.

Note:
Because of the maximum budget amounts allowed for special needs and the maximum grant amounts, a reduction in the actual cost of a special need may not result in a special needs reduction.

Notify SSA by Form 8220 when an enrollee has a special needs reduction or no longer requires a special need which was figured into the December 1973 state payment amount. Make appropriate changes in special needs on the Medicaid Eligibility Data System (MEDS). SSA will update the MIL by SDX.

No notification to SSA is required if there is no change in special needs.

Report to SSA on:

- Any changes in income and resources on Form 1610;
- Any incorrect conversion data not previously reported to SSA on Form SS-R-228; and

- Any special needs reduction on Form 8220.

N-360 REDETERMINATION PERIOD

The renewal period shall not exceed twelve (12) months.

N-400 OUT-OF-STATE MEDICAL CARE

N-410 General Information

Medicaid coverage is provided to eligible individuals who are absent from the State.

Medical claims for out-of-state services are honored in the following circumstances:

- When an emergency arises from an accident or illness;
- When the health of the enrollee would be endangered if the individual undertook travel, or if care and services are postponed until he returns to the state;
- When it is the general practice for residents of a particular locality to use medical resources in the medical trade areas outside the state; and
- When the medical care and services or needed supplementary resources are not available within the state. Prior authorization through state office is required.

N-420 SERVICES

Louisiana does not pay any out-of-state claims for Medicaid enrollees who are no longer Louisiana residents.
Payment for out-of-state long term care (LTC) nursing services will be made only when an enrollee is temporarily absent from the state with intent to return, and requires emergency nursing care in an out-of-state nursing facility. The out-of-state provider must enroll in Louisiana Medicaid before payment for services can be made.

Advise the applicant that there is no guarantee that out-of-state claims will be paid by Louisiana Medicaid.

When an out-of-state medical bill or inquiry is received in any office other than the Medicaid Management Information System (MMIS), it shall be forwarded to:

Bureau of Health Services Financing (BHSF)
Attention: MMIS Claims Processing Unit
P. O. Box 91030
Baton Rouge, LA 70821-9030

The agency will assist the provider in securing required Medicaid payment.

N-430 HEAD INJURIES/TRAUMATIC BRAIN INJURIES/REHABILITATIVE CARE

Medical assistance is provided to certain residents of Louisiana who are admitted to out-of-state LTC skilled nursing facilities (SNF) because of head injuries, traumatic brain injuries, or rehabilitative care. The applicant/enrollee must have the intent to return to Louisiana upon improvement in his/her medical condition. The individual must also have categorical eligibility determined before authorization for placement can be made. Should the individual be income ineligible, BHSF shall be notified that, upon entry into the facility, the individual would become eligible for LTC.

Placement of these individuals is approved by BHSF for this care that is not available in Louisiana. The Prior Authorization Unit and the Fiscal Intermediary review information from the medical provider to authorize the initial placement for level of care by Form 142. BHSF state office notifies the facility and the agency representative in writing of the authorization for placement and date of admission. This notification letter serves as the Form 148 used for LTC admissions.

An individual who is not Medicaid eligible must apply for LTC. An individual who is Medicaid eligible at the time of the injury must be determined eligible for LTC. Determine eligibility and patient liability using criteria for LTC eligibility.

Note:
Because BHSF has authorized the out-of-state placement of this individual, the Louisiana residency requirement for Medicaid eligibility is waived.

State Office shall notify the out-of-state facility of the decision, and if eligible, the patient liability and the procedure for billing. Form 148, with the return address of the LTC Processing Unit, shall be sent to allow the facility to notify the agency representative of the individual's discharge.

If the applicant is not eligible for LTC, consider eligibility in the Spend-Down Medically Needy – Long Term Care program (SD-MNP)-LTC). Refer to H-1040 Spend-Down Medically Needy - Long Term Care - SSI-Related. However, this will not allow vendor payment for out-of-state.

N-500 RESERVED

N-600 SUPPLEMENTAL SECURITY INCOME (SSI) — MEDICAID

N-610 INTRODUCTION

An enrollee of SSI is eligible for Medicaid without a separate application or eligibility determination.

SSI enrollees receive a medical eligibility card and are entitled to the full range of Medicaid covered services.

Notification of SSI eligibility is made by:

- A MEDS workflow sent to the analyst or supervisor; or
- Written verification from SSA.

N-620 CERTIFICATION PROCESS

SSI enrollees may be certified for Medicaid:

- Automatically by the SDX to MEDS interface; or
- Manually by adding eligibility on MEDS using the information from the SSA notification of eligibility.

Note:
If the manually input certification is not certified by State Data Exchange (SDX) within five (5) months, MEDS will add a renewal code to the SDX cert on MEDS. Code 8 indicates that a renewal evaluation be completed. The analyst should review the enrollee's continued SSI eligibility and confirm the accuracy of the identifying information.

If a workflow is received for an individual included in an active certification, verify actual residence prior to certification.

Contact SSA using BHSF Form SSI and request that SSA records and

parish code be corrected if the individual actually resides in the other parish.

If the SSI enrollee indicated having unpaid medical bills for the three months prior to SSI application shown on screen 4 of the MEDS AUMEM screen, consider retroactive Medicaid. Active SSI enrollees requesting retroactive Medicaid are shown on INFOPAC Report MED0200R7. Refer to H-700 SSI Retroactive Medicaid. SSI rejections requesting retroactive Medicaid are shown on INFOPAC Report MED0200R5.

Note:
The Qualified Medicare Beneficiary (QMB) certification is usually automatically sent by the SDX to MEDS interface. However, if a SSI enrollee eligible for Medicare is not certified, explore QMB eligibility.

Send notice of certification to the enrollee whose certification was processed automatically by the SDX to MEDS interface or manually added on MEDS.

N-630 CHILDREN IN THE CUSTODY OF THE CHILD WELFARE DIVISION OF THE DEPT. OF CHILDREN AND FAMILY SERVICES (CWD)

If SDX sends SSI eligibility for a child certified in a CWD category F (06), I (08), O (15), and V (22), MEDS will automatically change type case to 78. No change will be made to CWD categories.

A MEDS workflow is sent to CWD.

N-700 EXPRESS LANE ELIGIBILITY (ELE) – MEDICAID

N-710 INTRODUCTION

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 established an "Express Lane Eligibility" option to allow states to rely on findings from other state agencies to automatically enroll children into Medicaid programs.

N-720 CERTIFICATION PROCESS

Effective December 1, 2009, through a Supplemental Nutrition

Assistance Program (SNAP) to MEDS interface, children eligible for SNAP will be automatically certified for Medicaid for twelve (12) months, unless the family does not consent to enrollment into Medicaid.

Twelve (12) months continuous eligibility applies even if the SNAP case closes. Continuous eligibility ends if the child moves out of state or is deceased.

For processing procedures, Refer to the Express Lane Eligibility chapter of the *BHSF Eligibility Administrative Procedures Manual*.

N-800 MEDICARE IMPROVEMENT FOR PATIENTS AND PROVIDER'S ACT OF 2008 (MIPPA) - MEDICAID

N-810 INTRODUCTION

The Medicare Improvement for Patients and Provider's Act of 2008 (MIPPA) made changes to the Medicare Savings Programs (MSPs) to increase enrollment and reduce barriers to enrollment. MIPPA takes several steps to address the problem of low-income beneficiaries receiving the low-income subsidy who are eligible for MSP, but not enrolled. Under MIPPA, the federal asset limits for all MSPs (QMB, Specified Low-Income Medicare Beneficiary (SLMB) and Qualified Individual (QI)) will increase to the same level as the full Part D Low-income Subsidy (LIS).

N-820 CERTIFICATION PROCESS

Starting in January 2010, with the consent of applicants, the SSA will transmit data to Medicaid about LIS applicants through a file transfer interface. This data will be used by Medicaid to initiate an application for, and ultimately determine if the applicant is eligible for a MSP.

The application date for these MSP applications will be the date that SSA received the LIS application. The "pend date" will be the date Medicaid received the LIS data file and the days pending will be calculated from the "pend date".

Certify QMB no earlier than the month after the month of application. Certify SLMB or QI no earlier than the month of application. Eligibility for QMB, SLMB or QI shall not be retroactive. All MSP rejections will have appeal rights.

N-900 SNAP-ASSISTED ENROLLMENT

N-910 INTRODUCTION

Effective July 1, 2016, under a state plan option, the SNAP determination of total household gross income will be used to establish financial eligibility for Medicaid. This option efficiently enrolls SNAP-eligible adults certain to be eligible without requiring completion of another ~~a~~application or renewal form in addition to the SNAP application.

The SNAP participants, in households that are certain to be financially eligible for Medicaid, include only individuals under age 65 living in a household with no ineligible immigrants and with gross income, as determined by SNAP, at or below 138 percent of the Federal Poverty Limit (FPL). Additionally, the following criteria must be met:

- All members of the SNAP household are eligible for SNAP, other than for SNAP transitional benefits;
- Nobody in the SNAP household has any type of income that is included in Modified Adjusted Gross Income (MAGI)-based income, but is excluded in determining gross income for purposes of SNAP;
- Nobody in the SNAP household is part of a tax household that includes individuals who live outside the home; and
- The SNAP household falls into either of the following groups:
    - Households with individuals who live alone, parents living with their children, or married couples (with or without children), with no other members present who would not be included in the MAGI household; or
    - Other members are present in the household, but the total household income is below 138 percent FPL for a household size of one (1).

N-911 SNAP-Assisted Enrollment Letter

A letter is mailed to all of the targeted SNAP households. This letter:

- Lists the SNAP household members;
- Asks questions about MAGI income not counted in the SNAP household;

- Asks questions about the tax household of the SNAP members;
- Contains information on Medicaid rights and responsibilities, third-party liability and medical support requirements;
- Allows selection of a health plan; and
- Requires a signature.

N-920 CERTIFICATION

SNAP-assisted enrollment is not automatic. In order to determine that the SNAP household member is certain to be eligible, prior to enrollment, obtain additional information on MAGI income and tax household not included in the SNAP household. Also, prior to enrollment in Medicaid, a signature (either handwritten or telephonic) under penalty of perjury must be obtained.