N-0000 SPECIAL PROCESSING

N-150 RESERVED

N-160 RESERVED

N-200 LOCK-IN PROGRAM

N-210 DEFINITION

The Lock-In program serves as an educational tool for instructing beneficiaries in the use of Medicaid services in order to encourage a healthier lifestyle. The program monitors and ensures the appropriate use of Medicaid benefits by beneficiaries and/or providers. A beneficiary who has shown a pattern of misuse or overuse of program benefits may be placed into the lock-in mechanism to restrict access to providers.

Misuse or overuse can occur by:

- Obtaining prescriptions under the pharmacy program from various prescribers and/or pharmacies in an uncontrolled and unsound way; or
- Obtaining prescriptions or the dispersal of prescriptions by fraudulent actions.

Lock-In beneficiaries who misuse program benefits may be restricted to receive services from:

- One primary care physician of their choice;
- Up to three specialists of their choice;
- One pharmacy provider of their choice; and if needed,
- One specialty pharmacy.

The beneficiary is not prohibited from receiving other services available through Medicaid, which are not controlled or restricted by Lock-In.

N-220 EXCLUSIONS

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

Emergency Services

A beneficiary 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 a beneficiary 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 beneficiary may be placed in Lock-In Program who:

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

N-240 LOUISIANA DEPARTMENT OF HEALTH RESPONSIBILITIES IN PLACING THE BENEFICIARY IN LOCK-IN

Identification

Potential lock-in beneficiaries will be identified through review of various reports or by referral from other interested parties. Louisiana Department of Health (LDH) designee(s) in the Lock-In Unit, who are medical professionals, examine data for a consistent pattern of misuse/overuse of program benefits by a beneficiary. Contact with involved providers may be initiated for additional information.

The medical professionals render a recommendation to place a beneficiary in the Physician/Pharmacy Lock-In Program or Pharmacy-Only Lock-In Program. The decision making authority rests solely with the Louisiana Department of Health, Bureau of Health Services Financing (BHSF).

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

Pharmacy Benefits pharmacists make the decision to sign up a beneficiary in the Lock-In Program. BHSF or its representative shall forward a notification to the Lock-In Coordinator of the decision to enlist a beneficiary in the Lock-In Program.

Other Notification

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

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

Explanation of Lock-In Mechanism to the Beneficiary

Upon receipt of notification from LDH, the beneficiary shall be notified of the decision to lock-in providers and will include the following additional information:

- LDH's intention to allow the beneficiary to choose one pharmacy provider, one physician provider, and if needed up to three specialists and one specialty pharmacy;
- LDH will make payments only to the providers chosen by the beneficiary and approved by LDH;
- The beneficiary is advised to contact the fiscal intermediary to discuss the Pharmacy Lock-In Program; and
- The beneficiary has the right to appeal the initial Lock-In decision.

The department's fiscal intermediary shall be responsible for the following:

- Initiate contact with the beneficiary in instances when the beneficiary fails to contact the department, or its contractor;

- Conduct a telephone interview when warranted with the beneficiary regarding the Lock-In Program and the beneficiary's rights and responsibilities;
- Assist the beneficiary, if necessary, in exercising due process rights and complete the appropriate forms at the initial contact; and
- Notify Lock-In providers of their selection.

Medical Eligibility Card (MEC)

When a beneficiary is placed in the Lock-In program, the beneficiary's existing medical eligibility card is used. Once the provider information is approved by LDH Pharmacy Benefits Section, it is added to the beneficiary's Medicaid Enterprise System (MES) 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

Beneficiaries may change Lock-In providers every year without cause. When there is a "good cause" reason, beneficiaries may change Lock-In providers only with approval from LDH.

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

- The beneficiary relocates;
- The Lock-In provider requests that the beneficiary be transferred;
- The beneficiary's primary diagnosis changes; or
- The Lock-In provider stops participating in the Medicaid Program and does not accept Medicaid as reimbursement for services.

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

Beneficiary Profile Review

Beneficiaries' profiles are to be reviewed periodically as described in the Lock-In Procedure Manual (for determination of continuance or discontinuance of Lock-In). The department's medical designee(s) in the Lock- In Unit examines a beneficiary's profile for a continued pattern of misuse or overuse of program benefits.

Periods of ineligibility for Medicaid will not affect the Lock-In status of the individual. A review at the end of the first four months of ineligibility of Lock-In closure will be made to determine if Lock-In should be continued.

Based upon a recommendation of the department's medical designee, a decision may be made to restore unrestricted benefits and appropriate notification will be provided to the beneficiary.

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

States were required to provide a supplemental payment to former beneficiaries 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 beneficiary 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 beneficiary at the amount equal to his/her December 1973 income, including FITAP cash assistance payment.

Beneficiaries 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. The SSA will take action to stop or to reduce the MSS payment.

A converted case should not have an allowance for both an essential person and special care needs. If this has occurred, report to SSA 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 beneficiary 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 Children and Family Services (DCFS) 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 beneficiary by someone

outside his household because the beneficiary requires assistance with his/her personal needs, such as eating, bathing, dressing, getting about in his/her home, housekeeping, 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.

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 when a beneficiary 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 Louisiana Medicaid Eligibility Data System (LaMEDS). 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;
- Any special needs reduction; and
- Any incorrect conversion data not previously reported to SSA.

N-360 REDETERMINATION PERIOD

The renewal period shall not exceed 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 when:

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

Louisiana does not pay any out-of-state claims for Medicaid beneficiaries who are no longer Louisiana residents.

Payment for out-of-state long term care (LTC) nursing services will be made only when a beneficiary 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 Enterprise System (MES), it shall be forwarded to:

Bureau of Health Services Financing (BHSF)
Attention: MES 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/REHABILATATIVE/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/beneficiary 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

A beneficiary of SSI is eligible for Medicaid without a separate application or eligibility determination.

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

N-620 CERTIFICATION PROCESS

SSI beneficiaries may be certified for Medicaid:

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

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

If the SSI beneficiary indicated having unpaid medical bills for the three months prior to SSI application, consider retroactive Medicaid. Refer to H-700 SSI Retroactive Medicaid.

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

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

N-630 CHILDREN IN THE CUSTODY OF THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCFS)

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

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 uninsured children under the age of 19 into Medicaid programs.

N-720 CERTIFICATION PROCESS

Effective December 1, 2009, through a Supplemental Nutrition Assistance Program (SNAP) to LaMEDS interface, children eligible for SNAP will be automatically certified for Medicaid for 12 months, unless the family does not consent to enrollment into Medicaid.

Twelve-month continuous eligibility applies even if the SNAP case closes. Continuous eligibility ends if the child moves out of state or is deceased.

N-800 MEDICARE IMPROVEMENTS 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 (LIS) who are eligible for MSP, but not enrolled. Under MIPPA, the federal asset limits for all MSPs – Qualified Medicare Beneficiary (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

Effective January 1. 2010, with the consent of applicants, the SSA began to transmit data to Medicaid about LIS applicants through a file transfer interface. This data is used by Medicaid to initiate an application for, and ultimately determine if the applicant is eligible for an MSP.

The application date for these MSP applications will be the date the LIS application was filed with SSA. 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 three (3) months prior to the application. Eligibility for QMB shall not be retroactive. Refer to H-1100 Qualified Medicare Beneficiary. All MSP rejections will have appeal rights.

N-830 APPLICATIONS for LOW INCOME SUBSIDY

When a LIS application is received and the individual wants the State to make the LIS determination, the State shall consider the LIS application. The individual must be provided an opportunity without delay, a determination of eligibility decision for any low-income premium and cost sharing subsidies.

The State is responsible for any subsequent redeterminations for individuals determined eligible. If multiple applications are received, the later application is void if the individual has received a positive subsidy determination on an earlier application from the State or SSA.

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.

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.

N-1000 BUY-IN PROGRAM

N-1010 GENERAL PURPOSE

The Medicaid Program pays Medicare premiums for selected groups of eligible individuals. This is known as "Buy-In".

Purchasing Medicare coverage for certain Medicaid beneficiaries reduces Medicaid expenditures by shifting those expenditures to Medicare. The Medicaid program elected to "buy-in" Medicare Part B premiums beginning July 1985.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 mandated that the Medicaid Program expand Part B Buy-In coverage and extend Part A coverage to individuals meeting the Qualified Medicare Beneficiary (QMB) eligibility requirements. QMB Buy-In coverage began February 1989.

Note:
Recovery and Premium Assistance Unit is responsible for administering the Buy-In Program on the state level.

N-1020 PART A BUY-IN

The Medicaid Program pays Part A premiums for individuals who are not eligible for Premium-free Part A and qualify for QMB or Qualified Disabled Working Individuals (QDWIs).

Medicaid may only cover Part A premiums for QDWIs; however, the individual must be enrolled in Part B prior to the state accreting the record to their buy-in account.

Part A buy-in terminates when an individual qualifies for Premium-free Part A.

N-1030 PART B BUY-IN

The Medicaid Program pays Part B premiums for individuals eligible for QMB, SLMB, QI, SSI, and former SSI protected status.

The Medicaid Program pays Part B premiums for individuals eligible for Extended Medicaid regardless of MSP eligibility (DAC (section 1634(c) of the Act), PICKLE (42 CFR §435.135), and Disabled widow/ers (42 CFR §§ 435.137) and Early Widow/ers (435.138).

SSA identifies Medicare eligibility for all SSI beneficiaries entitled to Medicare and initiates the Buy-In process. SSI beneficiaries who reach age 65 are automatically eligible for QMB. If ineligible, CMS terminates the buy-in process.