POLICY AND PROCEDURE

POLICY NAME: Eligibility Guidelines	**POLICY ID:** LA.ELIG.01
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Eligibility
EFFECTIVE DATE: 02/2012	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 11/11, 1/13, 9/14, 12/14, 12/15, 10/16, 9/17, 9/18, 10/19, 7/20, 3/21, 5/22, 05/23, 10/23, 8/24	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy will define the eligibility guidelines and criteria for loading of the HIPAA 834 enrollment files.

PURPOSE:
To define Plan member eligibility guidelines in accordance with Plan's contract with Louisiana Department of Health (LDH).

SCOPE:
Louisiana Healthcare Connections (Plan) Eligibility Department, Member Services, and Centene Corporate Information Systems (IS).

DEFINITIONS:

POLICY:
Plan will manage the members within LDH eligibility guidelines and will adhere to the electronic file transfer protocol agreed upon between Plan and LDH's Enrollment Broker.

2.3.1 Mandatory Plan Populations – All Covered Services

Unless otherwise excluded in this section, the following Louisiana Medicaid Program populations are automatically enrolled into Managed Care Program for all MCO Covered Services:

2.3.1.1 Children under nineteen (19) years of age including those who are eligible under Section 1931 of the Social Security Act, poverty-level related groups, and optional groups of older children in the following categories:

- CHAMP-Child Program – Poverty level children under the age of nineteen (19) who meet financial and non-financial eligibility criteria. Deprivation or uninsured status is not an eligibility requirement;
- Deemed Eligible Child Program - Infants born to a woman determined eligible for the Louisiana Medicaid Program in any category on the date the infant is born, regardless of whether or not the infant remains with the birth mother, throughout the infant's first year of life. This includes an infant who is born to a mother who is determined eligible for the Louisiana Medicaid Program retroactive to the date the infant was born;
- Youth Aging Out of Foster Care (Chafee Option) - Children under age twenty-one (21) who were in foster care in the custody of any state on their eighteenth (18th) birthday, but have aged out of foster care;
- Former Foster Care Children – Individuals age eighteen (18) through twenty-six (26) who were enrolled in the Louisiana Medicaid Program and in foster care under the responsibility of the State on their eighteenth (18^{th}) birthday;
- Foster Care Children - Children under the age of eighteen (18) who are receiving foster care, kinship guardianship, or adoption assistance (Title IV-E).
- Regular Medically Needy Program - Individuals and families who meet the non-financial eligibility criteria for Parents and Caretaker Relative, Pregnant Women, or Children Under Age Nineteen (19) and whose income is at or below the Medically Needy Income Eligibility Standard;
- Family Opportunities Act for Disabled Children - Medicaid buy-in program for children under the age of nineteen (19) with disabilities who are not eligible for SSI due to income;
- LaCHIP Program – Uninsured low-income under the age of nineteen (19) who do not otherwise qualify for the Louisiana Medicaid Program; and
- Blind/Disabled Children and Related Populations - Individuals, generally under the age of 19, who are eligible for the Louisiana Medicaid Program due to blindness or disability.

2.3.1.2 Parents and Caretaker Relatives eligible under Section 1931 of the Social Security Act including:

- Parents and Caretaker Relatives Program - Individuals who are a relative of a dependent child by blood, adoption, or marriage and with whom the child is living, who assumes primary responsibility for the child's care, and meet financial and non-financial eligibility criteria; and
- Regular Medically Needy Program.

2.3.1.3 Pregnant Women - Individuals whose basis of eligibility is pregnancy including:

- LaMOMS Program - Pregnant women otherwise ineligible who receive full Louisiana Medicaid Program coverage through the calendar month in which the twelve (12) month postpartum period ends; and
- LaCHIP Phase IV Program – Provides full Louisiana Medicaid Program coverage from conception through delivery for low-income uninsured citizen and non-citizen pregnant women and their unborn children who are not otherwise eligible for the Louisiana Medicaid Program.

2.3.1.4 Breast and Cervical Cancer (BCC) Program - Uninsured women under age sixty-five (65) who are not otherwise eligible for the Louisiana Medicaid Program and are identified through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and are in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer.

2.3.1.5 Aged, Blind and Disabled Adults – Individuals who are age sixty-five (65) or older, blind, or have a disability; meet financial eligibility criteria; and do not meet the conditions for inclusion in the Voluntary MCO Populations, mandatory SBHS and Non-Emergency Ambulance Transportation (NEAT) populations, and mandatory SBHS and NEMT populations. These include:

- Supplemental Security Income (SSI) Program – Individuals nineteen (19) years of age and older who receive cash payments under Title XVI of the Social Security Act (Supplemental Security Income); and
- Extended Medicaid Programs - Certain individuals who lose SSI eligibility because of a Retirement, Survivors, Disability Insurance (RSDI) cost of living adjustment (COLA) or in some cases entitlement to or an increase in RSDI benefits. SSI income standards are used in combination with budgeting rules that allow the exclusion of COLAs and/or certain benefits. Extended Medicaid consists of the following programs:
  - Disabled Adult Children - Individuals over the age of eighteen (18) who became blind or disabled before the age of twenty-two (22) and lost SSI eligibility on or after July 1, 1987, as a result of entitlement to or increase in Social Security Child Insurance Benefits;
  - Widows/Widowers - Individuals who lose SSI eligibility because of receipt of RSDI early widow/widowers benefits;
  - Pickle - Individuals who concurrently receive RSDI; were eligible to receive both RSDI and SSI or Mandatory State Supplement (MSS) in at least one month since April 1, 1977, and lost SSI/MSS eligibility either:
    o Group One - as the direct result of an RSDI, COLA; or
    o Group Two - due to receipt of or increase in RSDI, other than an RSDI COLA, or receipt of or increase in other income and would again be eligible for SSI except for the RSDI COLAs received since the loss of SSI.
  - Disabled Widows/Widowers and Disabled Surviving Divorced Spouses Unable To Perform Any Substantial Gainful Activity - Widows/Widowers who became ineligible for SSI due to receipt of Social Security Disabled Widows/Widowers Benefits as long as they were receiving SSI for the month prior to the month they began receiving RSDI, they would continue to be eligible for SSI if the amount of the RSDI benefit was not counted as income, and they are not entitled to Medicare Part A; and
  - Blood Product Litigation Program - Individuals who lose SSI eligibility because of settlement payments under the *Susan Walker v. Bayer Corporation* settlement and the Ricky Ray Hemophilia Relief Fund Act of 1998;
- Medicaid Purchase Plan Program - Working individuals age sixteen (16) through sixty-four (64) who have a disability as defined by the Social Security Administration that can buy health coverage offered by the Louisiana Medicaid Program;
- Provisional Medicaid Program – Individuals with a disability as defined by the Social Security Administration or age sixty-five (65) or older, who meet the financial eligibility requirements for SSI, but are not receiving SSI; and
- Aged and related populations - Beneficiaries who are age sixty-five (65) or older and not members of the blind/disabled population or members of the Section 1931 Adult population.

2.3.1.6 Transitional Medicaid Program - Short-term coverage for families who lose Parents and Caretaker Relatives or Family Independence Temporary Assistant Program (FITAP, administered by DCFS) eligibility because of an increase in earnings.

2.3.1.7 Tuberculosis (TB) Infected Individual Program - Individuals who have been diagnosed as, or are suspected of, being infected with TB.

2.3.1.8 Adult Group – Individuals age nineteen (19) through sixty-four (64), not pregnant, not entitled to or enrolled in Medicare Part A or Part B, and not otherwise eligible for the Louisiana Medicaid Program.

2.3.1.9 Act 421 Children's Medicaid Option – Children under the age of nineteen (19), who have a disability as defined by the Social Security Administration and meet the level-of-care for a nursing facility, hospital, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

2.3.2 Voluntary MCO Populations

The Plan shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for all Specialized Behavioral Health (SBHS), NEMT services, and NEAT services.

2.3.2.1 If any such Beneficiary voluntarily enrolls into the Managed Care Program for all other Medicaid Covered Services, the Plan shall provide for all services as specified in the Services section of the Model Contract. These populations include:

- Non-dual eligible Beneficiaries receiving services through the following 1915(c) Home and Community-Based (HCBS) Waivers and any HCBS Waiver(s) that replaces these current Waivers:
  - Adult Day Health Care Waiver (ADHC) - Direct care in a licensed adult day health care facility for those individuals age twenty-two (22) and older who would otherwise require nursing facility services;
  - New Opportunities Waiver (NOW) – Services to individuals age three (3) and older who would otherwise require ICF/IID services;
  - Children's Choice Waiver (CC) - Supplemental support services to disabled children from birth to age twenty (20) on the NOW waiver registry;
  - Residential Options Waiver (ROW) – Services to individuals living in the community who would otherwise require ICF/IID services;
  - Supports Waiver – Services to individuals eighteen (18) years of age and older with a developmental disability which manifested prior to age twenty-two (22); and
  - Community Choices Waiver (CCW) – Services to persons aged sixty-five (65) and older or, persons age twenty-two (22) or older with adult-onset disabilities, who would otherwise require nursing facility services.
- Beneficiaries under the age of twenty-one (21), eligible for the Louisiana Medicaid Program who are listed on the Office for Citizens with Developmental Disabilities' (OCDD's) Request for Services Registry who are Chisholm Class Members.

2.3.2.2 Voluntary MCO populations may elect to receive all Medicaid Covered Services through the Managed Care Program at any time, effective the earliest possible month that the administrative action can be taken.

2.3.2.3 Voluntary MCO populations may return to FFS for all Medicaid Covered Services other than Specialized Behavioral Health and NEMT/NEAT services at any time, effective the earliest possible month that the administrative action can be taken.

2.3.2.4 Voluntary MCO populations who have previously returned to FFS for all Medicaid Covered Services other than Specialized Behavioral Health and NEMT/NEAT may elect to return to the Managed Care Program for all Medicaid Covered Services at any time, effective the earliest possible month that the administrative action can be taken.

2.3.3 Mandatory MCO Populations for SBHS and NEAT Services Only

The following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program for Specialized Behavioral Health Services and Non-Emergency Ambulance Transportation services only, and receive all other Medicaid Covered Services through FFS:

- Beneficiaries residing in Nursing Facilities (NF); and
- Beneficiaries under the age of twenty-one (21) residing in Intermediate Care Facilities for People with Developmental Disabilities (ICF/IIDs);

2.3.4 Mandatory MCO Populations for Specialized Behavioral Health and NEMT/NEAT Services Only

The following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program for SBHS and NEMT/NEAT services only, and receive all other Medicaid Covered Services through FFS:

- Beneficiaries who are enrolled in both the Louisiana Medicaid Program and Medicare (Medicaid dual eligible), except those residing in an institution as specified in this Section.
- LaHIPP Beneficiaries except those residing in an institution as specified in this Section.

2.3.5 Mandatory MCO Populations for All Covered Services except Specialized Behavioral Health and CSoC Services

The Plan shall accept Enrollment of children who are functionally eligible and participate in the CSoC program for all services as specified in the Services section of the Model Contract, except Specialized Behavioral Health Services and Coordinated System of Care (CSoC) services. For this population, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), and Substance Use Disorder (SUD) Residential services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7) remain the responsibility of the Plan. The Plan shall implement procedures to coordinate services it provides to the Enrollee with the services the Enrollee receives from the CSoC contractor, including sharing the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities as required by 42 CFR §438.208(b)(4).:

2.3.6 Excluded Populations

The following Louisiana Medicaid Program populations that cannot participate in the Managed Care Program and receive all Medicaid Covered Services through FFS:

- Beneficiaries age twenty-one (21) and older residing in ICF/IID;
- Beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete “managed care” type benefit combining medical, social and long-term care services;
- Refugee Cash Assistance;
- Refugee Medical Assistance;
- Take Charge Plus;
- Specified Low Income Medicare Beneficiary (SLMB) only;
- Qualified Individual Category 1 (QI 1);
- Qualified Disabled Working Individual (QDWI);
- Qualified Medicaid Beneficiary (QMB) only;
- Beneficiaries with a limited eligibility period including:
    - Spend-Down Medically Needy Program - An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Louisiana Medicaid Program coverage (up to three [3] months); and
    - Emergency Services Only - Emergency Services for aliens who do not meet Medicaid citizenship/ five (5) year residency requirements.

~~**2.3.72.3.6 Changes to Populations Groups**~~

~~LDH may add, delete, or otherwise change mandatory, voluntary opt-out, voluntary opt-in, and excluded population groups. If changed, the Contract shall be amended, and the Plan given sixty (60) Calendar days advance notice whenever possible.~~

CHANGES TO POPULATIONS:

~~**Changes to Populations Groups**~~

2.3.7 LDH may add, delete, or otherwise change mandatory, voluntary opt-out, voluntary opt-in, and excluded population groups. If changed, the Contract shall be amended, and the Plan given sixty (60) Calendar days advance notice whenever possible.

Where not listed herein this policy LHCC will adhere to all 834 identification of eligible membership as outlined by the 834 Companion Guide.

Last update to guide 5-9-24.

PROCEDURE:

1. The Plan will utilize the process with LDH and Enrollment Broker for the management in the electronic transmission and receipt of the 834 enrollment files.

2. On each business day, the Plan will process any HIPAA 834 Enrollment Files obtain from Enrollment Broker for any adds, changes, and disenrollment’s as provided on the file and load into our claims adjudication system.

3. Plan will accept for enrollment all eligible individuals as indicated on the 834 Enrollment files in the order in which they are assigned without restriction, up to the enrollment capacity limits set under the Contract with LDH, regardless of the individual’s age, sex, ethnicity, language needs, or health status.

4. The Plan shall not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health history, health status, need for health care services or adverse

change in health status; or on the basis of age, religious belief, sex/gender, ~~or~~ sexual orientation, gender identity, disability, race, color, or national origin. This applies to enrollment, re-enrollment, or disenrollment from the Plan.

5. All members enrolled in Plan will receive all Covered Services required to be provided to each member as of 12:01 a.m. on the enrollment date passed on the 834 enrollment file and shall remain until the Member is dis-enrolled. ~~Reference LA.ELIG.02~~

6. Plan will update member information including but not limited to member demographic information, county, eligibility begin, and end dates based on the information provided on the 834 enrollment file.

7. Plan will match new members to their selected PCP when provided on the 834 enrollment file unless one of the following is true:
   - PCP that has reached their maximum physician/patient ratio
   - PCP has restrictions/limitations (age/gender) for which that member does not qualify

   Members will be notified of the confirmation of their PCP selection on their member ID card mailed with their welcome packet.

8. The Plan will provide written notification to Enrollment Broker of any data inconsistencies within 10 calendar days of receipt of the data file.

9. The Plan will reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.

10. The Plan will report in writing to ~~LDH's Medicaid Customer Service Unit~~LDH Medicaid any changes in contact information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address if outside Louisiana, telephone number and insurance coverage utilizing an agreed upon procedure. Presuming that we receive an email for members on the 834, Plan will also provide changes to the member's email when we become aware. All data communications to follow reporting requirements as laid out in data transfer procedures between MCO, LDH, and Enrollment Broker. Current procedure transmits data on member demographic updates through LaMeds reporting directly to LDH Medicaid. LaMeds data feeds occur in real time. If a delay transmission occurs, LHCC will ensure manual transmission of the data within the (5) business day timeframe.

11. If the Plan discovers that a newborn was incorrectly enrolled in a different MCO than its mother for the month of birth, the Plan shall notify LDH immediately.
    a. Claims department shall be concurrently notified of newborns disenrolled, to follow contract requirements:
        i. For newborns incorrectly enrolled in a different MCO than its mother for the month of birth, the incorrectly enrolled MCO shall have no liability for the coverage of, or payment for, any services during the period of incorrect Enrollment. LDH shall be liable only for the Capitation Payment to the MCO in which the newborn is correctly enrolled and may recoup the Capitation Payment from the MCO in which the newborn was incorrectly enrolled.
        ii. For newborns disenrolled, the MCO in which the newborn was incorrectly enrolled shall not recover Claim payments from the provider. The MCO in which the newborn is incorrectly enrolled shall seek such Claim payments from the MCO in which the newborn should have been enrolled on the dates of service.

Enrollment Broker:

Per Department of Health and Hospitals Medicaid Contract 2.3 ELIGIBILITY and ENROLLMENT the items that DHH and it's designee (Enrollment Broker) will be responsible around disenrollment. These items are not the responsibility of Louisiana Healthcare Connections.

1. As part of the financial Medicaid application process, applicants may be given the option to indicate their preferred choice of CCN and PCP.

2. If the choice of CCN and PCP is not indicated on the new eligible file transmitted by DHH to the Enrollment Broker, the Enrollment Broker shall contact the eligible individual to request their choice of CCN and if available the PCP of choice.

3. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a CCN.

4. The name of PCP requested by a new enrollee will be included in the Member File from the Enrollment Broker to CCN.

REFERENCES:
LDH Model Contract 3.0, section 2.3.1 to 2.3.7

ATTACHMENTS:

Eligibility_Guidline_ Attachment.doc

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
HB 434 Act 319 applies to material changes to this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Added Eligibility Guidelines Attachment which outlines the responsibilities of DHH and the Enrollment broker	11/2011
Annual Review	Added LaCHIP Program and LaCHIP Affordable to Mandatory Eligibility.	01/2013
Annual Review	Added HCBS Waiver programs to Voluntary Populations section	09/24/14
Ad Hoc Review	LA Procurement 2015 Policy Update	12/01/14
Annual Review	BH changes	12/01/15
Annual Review	Added New adult population per amendment 6 Changed DHH to LDH Changed Bayou Health to Healthy Louisiana	10/24/16
Annual Review	Added section 3.0 of the DHH Medicaid Contract on references Changed Molina to Enrollment Broker Added sections 3.1 Eligibility Determinations, 3.2 Duration of Medicaid Eligibility, and 3.8 Excluded Populations Added Blind/Disabled Children & Related Populations and Foster Care Children to section 3.4 Replaced MCO with Plan	09/25/17
Annual Review	Changed… Healthy Louisiana to Medicaid Managed Care Plan to MCO in section 3.7 header Added… Non-Emergency Ambulance Transportation in section 3.3 For this population, PRTF, TGH, and Substance Use Disorder (SUD) Residential services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21) remain the responsibility of the MCO in section 3.3 to last bullet. In sections in Sections 3.5, 3.6, 3.7, and 3.8 the following to section 3.4. In the event that CHIP is not reauthorized with associated enhanced Federal funding, the eligibility changes will be made in accordance with Federal requirements and the public policy of the	09/25/18

	state. MCO membership may be impacted. To LaCHIP program bullet in section 3.4 In the event that CHIP is not reauthorized with associated enhanced Federal funding, eligibility changes will be made in accordance with Federal requirements and the public policy of the state. MCO membership may be impacted to LaCHIP Phase IV Program language in section 3.4 The MCO shall accept enrollment of the following Medicaid populations and provide for all Specialized Behavioral Health NEMT services and NEAT services. If any such beneficiary voluntarily enrolls into Medicaid Managed care for all other state plan covered services, the MCO shall provide for all services specified in Section 6. These populations include: to section 3.5 And any HCBS waivers that replaces these current waivers to non-dual eligible line under section 3.5 Elect to receive all other state plan services through Medicaid Managed Care line to Voluntary opt in population in section 3.5 NEMT to bullets two and three of Voluntary Opt in population under section 3.5 NEMT services language to section 3.6 header. NEAT language to bullet one under section 3.7. Bullets 2, 3, and 4 to section 3.7. Removed… Children functionally eligible and agrees to participate in the CSoC program (see exceptions to covered services in Section 3.3.3.4 from section 3.4. Medicaid populations that are mandatorily enrolled into Healthy Louisiana and NMET Services only, and may voluntarily enroll into Healthy Louisiana for other state plan covered services line from section 3.5 under age 18 from children's choice bullet under section 3.5 mental retardation under supports waiver bullet in section 3.5 effective the earliest month that the action can be administratively taken from third voluntary opt in bullet under section 3.5. GNOCHC line from section 3.8	
Annual Review	No revisions	10/24/19
Annual Review	No revisions	07/24/20
Annual Review	No revisions	03/25/21
Annual Review	No Revisions	05/27/22
Annual Review	Reformatted to latest Policy Template Updated language to match new Model Contract 3.0 Updated References and Regulatory Reporting Requirement Added item 11 in Procedure section	05/09/23
Ad Hoc Review	Updated procedure section to include non-discrimination verbiage	10/16/23
Annual Review	Attachment information combined into section of policy rather than including as a separate attachment. Removal of specific department referenced and added data transmission procedural information. Add attachment for Medical Companion Guide (used to identify and process members as eligible).	8/9/24

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.