Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2303. Family Opportunity Act Medicaid Program

A. The Family Opportunity Act, signed into law by Congress as part of the Deficit Reduction Act of 2005, allows states to offer a Medicaid buy-in program to families with income up to 300 percent of the federal poverty level (FPL) for children with disabilities who are not eligible for Supplemental Security income (SSI) disability benefits due to excess income or resources. The department hereby implements a Medicaid buy-in program called the Family Opportunity Act Medicaid Program to provide Medicaid coverage to children with disabilities.

B. Eligibility Requirements. Children born on or after October 1, 1989, up to age 19, and who meet the following requirements may receive health care coverage through the Family Opportunity Act Medicaid Program.

1. The child must have a disability which meets the Social Security administration's childhood disability criteria.

2. Gross family income must not be more than 300 percent of the federal poverty level using the income methodologies of the SSI program.

a. For the purpose of determining family income, the family unit shall consist of the following members:

i. child(ren) with disabilities;

ii. natural or legal parent(s); and

iii. siblings under age 19.

b. Step-parents and step-siblings are excluded from the income determination.

3. The child may be uninsured or underinsured.

a. Parents are required to enroll in available employer-sponsored health plans when the employer contributes at least 50 percent of the annual premium costs. Participation in such employer-sponsored health plans is a condition of continuing Medicaid coverage.

C. Children determined eligible under the Family Opportunity Act Medicaid Program shall receive coverage of medically necessary health care services provided under the Medicaid state plan.

D. Premium Payments. Families with gross income above 200 percent, but not more than 300 percent of the FPL, are required to pay premiums for Medicaid coverage. Families with gross income up to 200 percent of the FPL are not required to pay premiums for Medicaid coverage.

1. The amounts paid for premiums for Medicaid-required family coverage and other cost-sharing may not exceed 5 percent of a family's income for families with income up to 200 percent of the FPL and 7.5 percent of a family's income for families with income above 200 percent of the FPL.

2. For families with gross income above 200 percent, but not more than 300 percent of the FPL, the premium amount for Medicaid is determined by whether the natural or legal parent(s) living in the household is paying for other creditable health insurance that covers the child(ren) with disabilities.

a. Families who have other creditable health insurance that provides coverage to the child(ren) with disabilities will pay a family Medicaid premium on a sliding scale as follows:

i. $12 per month for families with income above 200 percent and up to 250 percent of the FPL;

ii. $15 per month for families with income above 250 percent, but not more than 300 percent of the FPL.

b. Families who do not have other creditable health insurance that provides coverage to the child(ren) with disabilities will pay a family Medicaid premium on a sliding scale as follows:

i. no premium is required for families with income from 0 percent and up to 200 percent of the FPL;

ii. $30 per month for families with income above 200 percent and up to 250 percent of the FPL;

iii. $35 per month for families with income above 250 percent, but not more than 300 percent of the FPL.

3. The first premium is due the month following the month that eligibility is established. Prepayment of premiums is not required. A child's eligibility for medical assistance will not terminate on the basis of failure to pay a premium until the failure to pay continues for at least 60 days from the date on which the premium was past due.

4. The premium may be waived in any case where it is determined that requiring a payment would create an undue hardship for the family. Undue hardships exist when a family:

a. is homeless or displaced due to a flood, fire, or natural disaster;

b. resides in an area where there is a presidential-declared emergency in effect;

c. presents a current notice of eviction or foreclosure; or

d. has other reasons as determined by the department.

5. Families whose eligibility has been terminated for non-payment of premiums must pay any outstanding premium balances for Medicaid-covered months before eligibility can be re-established, unless:

a. the liability has been canceled by the Bureau of Appeals or the Medicaid Recovery Unit; or

b. there has been a lapse in Medicaid coverage of at least 12 months.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1628 (August 2008), amended LR 35:69 (January 2009).

§2305. Provisional Medicaid Program

A. The Provisional Medicaid Program provides Medicaid-only coverage to individuals who:

1. are aged or have a disability; and

2. meet income and resource requirements for supplemental security income (SSI) cash assistance.

B. The Provisional Medicaid Program provides coverage to individuals with income equal to or less than the federal benefit rate (FBR), and resources that are equal to or less than the resource limits of the SSI cash assistance program.

C. A certification period for the Provisional Medicaid Program shall not exceed 12 months.

D. Retroactive coverage up to three months prior to the receipt of the Medicaid application shall be available to recipients in the Provisional Medicaid Program.

1. Any retroactive coverage period shall not be prior to the implementation date of the Provisional Medicaid Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1118 (June 2015).

§2307. Youth Aging Out of Foster Care

A. Pursuant to section 477 of the Foster Care Independence Act of 1999 (Public Law 106-169) and Act 352 of the 2008 Regular Session of the Louisiana Legislature, the Department of Health and Hospitals hereby implements a Medicaid eligibility group, effective March 1, 2009, to provide health care coverage to youth who are transitioning out of foster care to self-sufficiency upon reaching age 18. This eligibility group will be called youth aging out of foster care.

B. Eligibility Requirements. Youth who are aging out of foster care on or after March 1, 2009 and meet all of the following requirements may receive Medicaid health care coverage under this new eligibility group.

1. The youth must be from age 18 up to age 21.

2. The youth must have been in foster care and in state custody, either in Louisiana or another state, upon obtaining age 18.

3. The youth must live in Louisiana.

C. Income, resources and insurance status are not considered when determining eligibility.

D. Individuals determined eligible in this group shall receive coverage of medically necessary health care services provided under the Medicaid state plan.

1. The assistance unit shall consist of the youth only.

E. Eligibility for the program will continue until the youth reaches age 21 unless the youth:

1. moves out of state;

2. requests closure of the case;

3. is incarcerated; or

4. dies.

F. Application Process. No application is required for this eligibility group. Closure of a foster care case due to the youth reaching age 18 establishes eligibility.

G. Certification Period. The certification period shall begin the month the youth reaches age 18 and will end on the last day of the month in which the youth reaches age 21.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2449 (November 2009).

§2308. Former Foster Care Adolescents

A. Pursuant to the Patient Protection and Affordable Care Act of 2010 (collectively referred to as the Affordable Care Act), the Department of Health and Hospitals hereby implements a Medicaid eligibility group, effective December 31, 2013, to provide health care coverage to youth who are transitioning out of foster care to self-sufficiency upon reaching age 18 or at a higher age selected by the department. This eligibility group will be called former foster care adolescents.

B. Eligibility Requirements. Youth who age out of foster care and meet all of the following requirements may receive Medicaid health care coverage under this new eligibility group.

1. The youth must be from age 18 up to age 26.

2. The youth must have been in foster care and in state custody, either in Louisiana or another state, and receiving Medicaid upon turning age 18 or upon aging out of foster care at a higher age selected by the department.

3. The youth must live in Louisiana.

C. Income, resources and insurance status are not considered when determining eligibility.

D. Individuals determined eligible in this group shall receive coverage of medically necessary health care services provided under the Medicaid state plan.

1. The assistance unit shall consist of the youth only.

E. Eligibility for the program will continue until the youth reaches age 26 unless the youth:

1. moves out of state;

2. requests closure of the case;

3. is incarcerated; or

4. dies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2260 (November 2014).

§2309. Medicaid Purchase Plan [Formerly LAC 50:III.763-765]

A. Effective January 1, 2004, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing implemented the Medicaid Purchase Plan Program for workers with disabilities under title XIX of the Social Security Act. The Medicaid Purchase Plan allows persons who meet the Social Security disability criteria to seek the employment services, vocational rehabilitation services, and other support services needed to obtain, regain or maintain employment, and reduce their independence on cash benefit programs.

B. Recipient Eligibility. Effective January 1, 2014, the Medicaid purchase plan shall cover workers with disabilities who meet the following criteria:

1. are employed;

2. are age 16 through age 64;

3. meet the Social Security Administration criteria for disability;

4. have net income less than 100 percent of the federal poverty level;

5. have countable resources (assets) less than $10,000;

a. all life insurance policies, medical savings accounts, and retirement accounts shall be counted towards the resource limit; and

6. are enrolled in no-cost health insurance.

C. Spousal income and resources shall be counted towards the income and resource limits.

D. Effective January 1, 2014, buy-in premiums shall be eliminated from the Medicaid Purchase Plan Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3299 (December 2013).

§2313. Medically Needy Program

A. The Medically Needy Program (MNP) provides Medicaid coverage when an individual's or family's income and/or resources are sufficient to meet basic needs in a categorical assistance program, but not sufficient to meet medical needs according to the MNP standards.

1. The income standard used in the MNP is the federal medically needy income eligibility standard (MNIES).

2. Resources are not applicable to modified adjusted gross income (MAGI) related MNP cases.

3. MNP eligibility cannot be considered prior to establishing income ineligibility in a categorically related assistance group.

B. MNP Eligibility Groups

1. Regular Medically Needy

a. Prior to the implementation of the MAGI income standards, parents who met all of the parent and caretaker relative (PCR) group categorical requirements and whose income was at or below the MNIES were eligible to receive Regular MNP benefits. With the implementation of the MAGI-based methodology for determining income and household composition and the conversion of net income standards to MAGI equivalent income standards, individuals who would have been eligible for the Regular Medically Needy Program are now eligible to receive Medicaid benefits under the parent and caretaker relative eligibility group. Regular medically needy coverage is only applicable to individuals included in the MAGI-related category of assistance.