PROVIDER BULLETIN

News and Updates on the Louisiana Medicaid Provider Portal

This Provider Bulletin was developed to answer questions and address concerns providers may have regarding Medicaid's new enrollment and eligibility system. Launched on November 13, 2018, the new system includes a new Provider Portal that replaces the former Facility Notification System (FNS) as ***the primary way providers manage documentation requirements****. The Self-Service Portal can be accessed at https://sspweb.lameds.ldh.la.gov/selfservice/.*

Medicaid Long Term Care Renewals

Renewals for long-term care enrollees will begin in June 2019. These renewals will include all renewals scheduled between October 2018 – May 2019 that were postponed following the implementation of Medicaid's new eligibility and enrollment system in November 2018. The bulk of the long-term care population, roughly 80 percent, should receive a request by mail from Medicaid to renew their coverage. **Failure to respond will result in loss of coverage.**

The renewal letter will be sent to the mailing address provided to Medicaid on the application or at last renewal, which may not be the same address as the provider. In order to address this, LDH has taken measures to ensure providers get information about enrollees undergoing renewal in June. LDH will be sending lists of long-term care enrollees undergoing renewal in June to individual nursing facility providers and support coordination agencies as listed on the enrollee's Medicaid case file. NOTE: This only applies if the provider is listed on the enrollee's case.

What to Expect

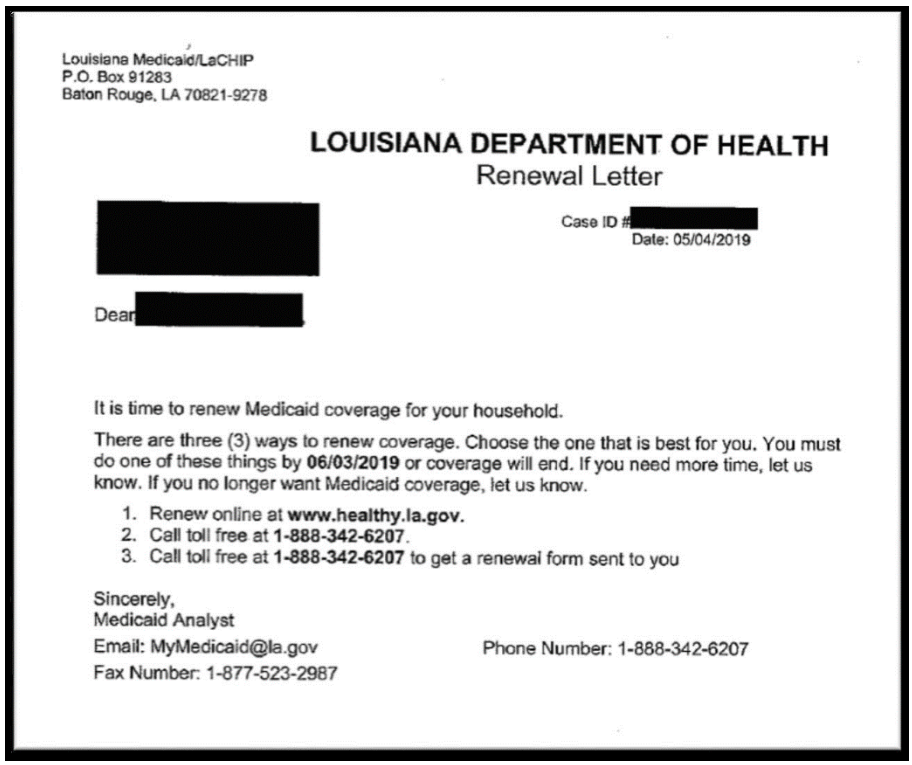
Letters are scheduled to be mailed June 3, 2019. A sample, redacted letter is included below. Dates on the notice will be different, but the enrollee will still have 30 days to respond.

The process for renewals is as follows:

Step 1: Medicaid will check eligibility in our system for all long-term care enrollees who have a renewal date between October 1, 2018 and May 31, 2019.

Step 2: Anyone that remains eligible within program limits based on data sources already available in the Medicaid system will be sent a decision letter noting their continued coverage. No response is necessary.

Step 3: Anyone for whom the system produces data indicating a discrepancy or that the person is over program limits will receive a renewal letter. A sample of the letter is to the right. Please work with your patients to ensure they are responding to this letter by the deadline.



Louisiana Medicaid/LaCHIP
P.O. Box 91283
Baton Rouge, LA 70821-9278

LOUISIANA DEPARTMENT OF HEALTH
Renewal Letter

[redacted]

Case ID #[redacted]
Date: 05/04/2019

Dear [redacted]

It is time to renew Medicaid coverage for your household.

There are three (3) ways to renew coverage. Choose the one that is best for you. You must do one of these things by **06/03/2019** or coverage will end. If you need more time, let us know. If you no longer want Medicaid coverage, let us know.

1. Renew online at **www.healthy.la.gov.**
2. Call toll free at **1-888-342-6207**.
3. Call toll free at **1-888-342-6207** to get a renewal form sent to you

Sincerely,
Medicaid Analyst
Email: MyMedicaid@la.gov
Phone Number: 1-888-342-6207
Fax Number: 1-877-523-2987

Help with Renewal

The Medicaid renewal letter offers three ways to renew. The fastest and easiest way to renew is online through the Medicaid Self-Service Portal. It pre-populates data for you. Medicaid has created a number of resources to help guide enrollees through the online renewal process. **How to guides with step by step screenshots for how to complete a renewal can be found here.** For nursing facilities that registered as trusted users, you will be able to do renewals on behalf of your residents under a single login. For more information on how to become a trusted user, go to the LNHA Resource Library here.

Renewal Lists

Nursing facilities requesting renewal lists from the Office of Aging and Adult Services (OAAS) should send these requests to OAAS.Inquiries@la.gov. Such requests should not be sent to OAAS's Nursing Facility Admissions Unit.

OAAS will send renewal information to nursing facilities statewide using the primary email address contact provided to OAAS by the Louisiana Nursing Home Association (LNHA). These emails will be sent within 48 hours of receipt of the renewal information from Medicaid. The emails to nursing facilities will come from a different OAAS staff member each time, but all emails will come from an address ending with la.gov.

Reminder: Paper Renewals

Some enrollees or providers have tried to complete renewals on a defunct 2-L paper renewal form for long-term care. This form was retired a few years ago and is not currently accepted by the program. Please ensure that you and your clients are not submitting this form, but are instead following the instructions on the renewal letters.

Spousal Impoverishment

As a general rule, Medicaid enrollees must meet certain financial eligibility criteria in order to qualify for Medicaid. For long-term care (LTC), the Medicaid program looks to the income and resources of a person's household, and, generally, enrollees are expected to use their resources to meet their needs, including the cost of care, before becoming eligible for Medicaid coverage of LTC.

In order to both ensure those who need care can get it and safeguard family members against difficult financial situations, Medicaid rules provide protections against what is commonly referred to as "spousal impoverishment." Spousal impoverishment rules allow a nursing facility resident to allocate resources to his or her spouse living in the community.

Spousal impoverishment protections exist for LTC enrollees whether the care is facility-based or home- and community-based services (HCBS). The rules that apply for HCBS enrollees differ somewhat from the ones we describe below, which apply to nursing facility residents. HCBS providers should look for information on the rules that apply to HCBS enrollees in an upcoming provider bulletin.

Below are some basics on spousal impoverishment. Remember that if you are helping a resident apply for or renew Medicaid through the Self-Service Portal, you must ensure that the information regarding finances is complete and correct. If the resident is married, this likely means consulting with both the resident and his or her spouse to obtain information and required documentation.

What is a resource?

Resources are cash or any property that an individual (or spouse, if any) owns and could convert to cash to be used for his/her support and maintenance.

Not all resources count against the Medicaid limit. A family home, one vehicle per household, property essential for self-support, household goods, and personal effects generally do not count against the Medicaid resource limit. All other resources are "countable" against the Medicaid limit.

Whose Resources Count?

In certain situations, the law requires other people to share financial responsibility for a person applying for or enrolled in the Medicaid LTC program. To determine the resources of the applicant/enrollee, you must count the resources of:

- The applicant/enrollee in the nursing facility.
- The applicant/enrollee's legal spouse living in a non-institutionalized setting (the "community spouse"), if the couple lived together in the same household before the applicant/enrollee entered the nursing facility.
- Applicants/enrollees who are a legally married and residing in the same nursing facility, though they may elect to be considered as individuals.

In the case of a minor applicant/enrollee, count the resources of the parent(s) with whom the child lived in the month prior to admission to the nursing facility. After the first month, only count the resources of the applicant/enrollee.

Which resources count?

As noted above, you should exclude the family home, up to one vehicle, personal effects, household goods, and items that are necessary for self-support.

Otherwise, include the property of both spouses, whether the property is separate or community property. Include property even if under a prenuptial agreement, matrimonial agreement, or a separation of property agreement.

How are resources valued?

For Medicaid purposes, the value of a resource is the amount it can be expected to sell on the open market in the particular geographic area (fair market value), less any legal binding debt (for example, a mortgage) on the resource.

Resource eligibility is a determination made as of the first day of each calendar month and is applicable to the entire month. Subsequent changes during the month have no effect until the following month's resources determination.

Resource Eligibility – Basic Rule

For Medicaid, countable resources cannot exceed $2,000 per individual, or $3,000 per couple. If the countable resources are equal to or less than this limit, the applicant/enrollee is resource eligible for the LTC program. Generally, if the countable resources are greater than the applicable resource limit, the applicant/enrollee is not eligible for Medicaid LTC coverage.

Couples living in the same facility may be treated as individuals for the purpose of resource calculation, meaning, each spouse may have up to $2,000 in resources.

Resource Eligibility - Spousal Impoverishment

A married applicant/enrollee can give resources to his or her spouse in order to achieve Medicaid eligibility.

This policy applies to any applicant/enrollee who:

- Meets all other Medicaid requirements; and
- Has a legal spouse living in a non-institutional setting (in the community); and
- Lived with his or her spouse prior to entering the nursing facility; and

- Entered the nursing facility on or after September 30, 1989. If a resident entered the facility prior to 1989, ask for guidance from your facility's LTC Claims Analyst.

If a couple's combined resources exceed the limits given above, the spouse in the nursing facility must give their resources to the community spouse in order to be eligible for Medicaid.

Medicaid sets a limit, known as the "Spousal Resource Standard" on the amount of combined countable resources that may be given to the community spouse. The applicable Spousal Resource Standard is based on the date of the applicant/enrollee's most recent new admission to the nursing facility. Spousal Resource Standards can be found here.

Spousal Resources Assessment

Medicaid completes a resource assessment for the couple as of the first day of the month of the most recent admission to the nursing facility to determine the couple's combined countable resources.

Medicaid subtracts the Spousal Resource Standard from the couple's combined countable resources. If the remaining resources are equal to or below the resource limit for an individual ($2,000), the applicant/enrollee is eligible for Medicaid LTC (as long as resources over the limit were given to his or her spouse as noted above). If the remaining resources are above the resource limit for an individual, the applicant/enrollee is not eligible.

Allocation of Resources

If the spouse in the nursing facility is eligible based on giving resources to the community spouse, both spouses must execute a Transfer of Resources Acknowledgment form, which gives the amount of resources that must be allocated to the community spouse in order to retain Medicaid coverage. The form will be sent to the community spouse or, where applicable, an authorized representative, and will already be filled out with asset information Medicaid has.

The resources must be given to the spouse by the first annual Medicaid renewal in order for the spouse in the nursing facility to remain Medicaid eligible.

Proper Identification on Newborn Forms

When completing newborn forms, providers are reminded to only include the mother's information. Some providers have submitted newborn forms that inaccurately list the father's identifying information (name, Medicaid ID number, Social Security number and date of birth) instead of the mother's information. This causes the infant to be deemed eligible under the father's case without the mother's awareness. In cases when the mother also applies for coverage for her baby, the baby is then assigned to both parents' cases and assigned two ID numbers.

Reminder: Waiver Applications and Health Plan Selection

Medicaid has confirmed that selection of a health plan during Medicaid waiver application online does not automatically put the applicant into managed care for physical health.

All waiver applicants initially go into a behavioral health only category. Physical health services will be provided through fee-for-service Medicaid. Once certified, the recipient can choose to opt-in to managed care for physical health, but they must make a proactive choice.

Provider Call Schedule

Beginning June 19, Louisiana Medicaid will move its weekly nursing facility calls to bi-weekly. Support coordinator calls will continue to be bi-weekly. After July 31, all calls will move to monthly.

The nursing facility and support coordinator calls serve as an opportunity to share LDH announcements, answer questions from callers, and cover requested agenda topics submitted by call participants. Agenda topics can be submitted online here. If no agenda items are received by the close of business on Monday prior to each call, that week's call will be cancelled. All agendas, meeting minutes and any meeting cancellation notices will be posted here.

For more information on the nursing facility and support coordinator calls, including agendas and minutes, click here.