TABLE OF CONTENT

04.10 INTRODUCTION

The eligibility process for CLTC waiver applicants is completed through coordination between the CLTC office and the Medicaid Eligibility office. Waiver applicants must meet the financial and categorical criteria for Medicaid and meet level of care for home and community-based services initially and on an on-going basis as a participant.

04.20 MEDICAID FINANCIAL ELIGIBILITY POLICIES AND PROCEDURES

04.21 Medicaid Financial Eligibility Determination Process

Verifying an applicant's Medicaid financial and categorical eligibility is an important function of the **CLTC Centralized Intake Team** in the pre-admission process. The applicant and/or primary contact should always be informed of the application process.

1. If an applicant is not currently receiving Supplemental Security Income Category 80 (SSI) and it appears s/he may qualify, the applicant should be referred to Social Security, unless a recent application has been made.

2. If an applicant is not presently eligible for any Medicaid Category and is seeking Medicaid-sponsorship in a long term care facility or community-based services, an application for Medicaid financial and categorical eligibility must be made with the Medicaid Eligibility Office. **The Centralized Intake Team** informs the applicant/primary contact to apply for Medicaid at the Medicaid Eligibility Office or electronically at apply.scdhhs.gov. The Medicaid Eligibility Application for Nursing Home, Residential or In-Home Form 3401 is mailed to the applicant with an addressed envelope labeled: SCDHHS Central Mail Center, PO Box 100101, Columbia, SC 20202-3101.

3. If an applicant is presently eligible for Medicaid for any category other than through Category 80 (SSI) or Category 32 (ABD) and is seeking community-based services, an application for Medicaid financial and categorical eligibility must be made with the Medicaid Eligibility Office. **The Centralized Intake Team** informs the applicant/primary contact to apply for Medicaid waiver approval at the Medicaid Eligibility Office or electronically at apply.scdhhs.gov. The Medicaid Eligibility Additional Information for Institutional and In-Home Care Form 3400B is mailed to the applicant with an addressed envelope labeled: SCDHHS Central Mail Center, PO Box 100101, Columbia SC 20202-3101.

4. If an applicant is presently eligible for Medicaid Category 80 (SSI) and is seeking community based services, **Centralized Intake Team** processes the application and releases the application to the Area Office.

5. If an applicant is presently eligible for Medicaid Category 32 (ABD) and is seeking community-based services, **Centralized Intake Team** processes the application and releases the application to the Area Office.

04.22 Verification of Medicaid Financial Eligibility

An applicant's Medicaid financial eligibility must be verified by the **Nurse Consultant** before s/he is entered into the waiver and the **Case Manager** must verify continued financial eligibility **monthly** thereafter. Documentation of eligibility verification by the **Assigned Worker** is **required initially, quarterly** and **at re-evaluation** for participants and must be reflected in the Narrative and consistent with the appropriate sections of Phoenix (RSP, Participant Information).

The "Financial Eligibility Verified" field is used to indicate that the applicant meets all financial criteria. For applicants with an eligibility category of 80, 16, 54, 86, 33, and 10, the field should be checked in Phoenix. **NOTE**: For Category 10 see Section 04.23.10. All other eligibility categories require an application approval notification in the Eligibility Workflow section of Phoenix from the Regional Institutional Eligibility Worker before the verification field is checked. When the approval notification is received, the designated Area Office staff must check the field. If at any point the applicant becomes financially ineligible, immediate investigation is required to determine what action is necessary or if termination is appropriate. (Refer to Section 5.38.10)

If a case is released to the CLTC Area Office which does not have an Eligibility Workflow, a Phoenix problem should be reported.

The applicant's Medicaid eligibility status can be verified by one of the following methods:

1. Verification from MMIS (via MMIS or related Phoenix link);

2. Verification from Medicaid Eligibility via the Eligibility Workflow section in Phoenix;

3. Specific current documentation from the applicant (SSI check, letter or documentation from the Social Security Administration, etc.); or,

4. Verification via Phoenix. This must be checked **at least monthly**.

If Medicaid Eligibility Office determines an applicant is financially ineligible, s/he must not enter into the CLTC program. If a participant is currently enrolled in the CLTC program/waiver, follow policy outlined in 5.38.10.

04.23 Transfer of Resources

Federal regulations require Medicaid Eligibility to review the case of any

Medicaid applicant or recipient who enters a nursing home or a home and community- based waiver to determine if any transfer of resources has occurred.

1. MAO (Category 15) - Resource verification is completed by Medicaid Eligibility as a normal part of the eligibility determination process, prior to providing approval notification in Eligibility Workflow section of Phoenix to CLTC indicating that the applicant is financially eligible. No further action concerning transfer of resources is required of the CLTC **Nurse Consultant**.

2. ABD (Category 32) - A Statement of Transfer of Assets Form 3400D is completed by the **Nurse Consultant**. The original is mailed to SCDHHS Central Mail Center and a copy is scanned in the applicant's Phoenix record. NOTE: Applicants who indicate they have made a transfer of assets below market value are not enrolled or terminated until a response is received from Medicaid Eligibility Workflow.

3. All Other Categories of Medicaid Eligibility EXCEPT SSI (Category 80, 16, 54, 86) and ABD (Category 32 and 33) - The resource verification must be completed by Medicaid Eligibility prior to approving the Eligibility Workflow in Phoenix. A response from Medicaid Eligibility is required before entering the applicant into the waiver.

   NOTE: FOR CATEGORY 71 (Breast and Cervical Cancer) ONLY, a CLTC Notification Form must be sent to the Division of Eligibility Policy and Oversight, Jefferson Square, Suite 856 for coordination. This can be done through interagency mail.

The **Centralized Intake Team**:

- Determines if the applicant is currently Medicaid financially eligible.

- Provides Medicaid Eligibility Application for Nursing Home, Residential or In-Home Form 3401 to applicant who is not currently Medicaid eligible

- Provides Medicaid Eligibility Additional Information for Institution and In-Home Care Form 3400B to applicants who have any Medicaid Payment Category other than Categories 80, 33, 16, 54, 86.

- For the applicant who is not currently financially eligible, verifies after 30 days that an application has been made with Medicaid Eligibility. If no

application has been made with Medicaid Eligibility, a 10 day notice should be sent using the CLTC Notification Form 171. If no response is received, the case can be closed upon the discretion of the Intake Nurse Consultant.

- Receives notification from Medicaid Eligibility via the Eligibility Workflow that the application has been approved and releases the case to the Area Office.

- Receives notification from Medicaid Eligibility via the Eligibility Workflow that the application has been denied, terminates the application and notifies the applicant/primary contact via the CLTC Notification Form.

The **Nurse Consultant:**

- Determines if the applicant is currently Medicaid financially eligible.

- Enters Medicaid status in Phoenix if the Eligibility Workflow notification is received as approved.

- Completes the Statement of Transfer of Asset Form 3400D for Category 32 (ABD) applicant.

- At the point of case transfer, reviews the applicant's Medicaid status with the **Case Manager**.

The **Case Manager** will for an applicant entering the waiver:

- Review the applicant's current Medicaid status with Nurse Consultant at time of case transfer.

- E-mails waiver enrollment confirmation to the **Designated Staff** to ensure entry of enrollment date on MMIS/RSP update screen **within four (4) calendar days**.

- Complete the CLTC Notification Form 171 to notify the applicant/primary contact and other appropriate agencies of the applicant's entry into the CLTC waiver. Medicaid Eligibility will be notified of waiver enrollment via the Eligibility Workflow in Phoenix.

- Assess the applicant's circumstances for indications of possible changes which may occur in the applicant's Medicaid status.

Note: If an applicant's eligibility category changes from one category to another with no interruption in Medicaid eligibility, it is not necessary to check for transfer of resources. See also Chapter 5 for on-going quarterly and re-evaluation verification requirements.

If Medicaid Eligibility finds a sanctionable transfer, Medicaid Eligibility will deny the application in Eligibility Workflow section in Phoenix and indicate in the Comment Section that the applicant is "Subject to transfer penalty. Not eligible for waiver services until (date) ".

The applicant is not eligible for waiver enrollment during the period s/he is subject to the transfer penalty. If the penalty period specified by Medicaid Eligibility in the Eligibility Workflow notification **is thirty (30) days or less** from the date received by the local CLTC office, the case may continue in a pending status until the penalty period expires. If the penalty period **exceeds thirty (30) days**, the case must be terminated as Medicaid financially ineligible.

04.23.10 Applicant Leaving Nursing Home and Entering Waiver

For an individual who is in a nursing facility under **Medicaid sponsorship** (Category 10 or SSI) and is discharged to a home and community-based waiver, a look back for transfer of resources prior to enrollment in a waiver is **not** required if the applicant enters the waiver within ten (10) calendar days of the discharge from the nursing facility.

MAO (Category 10) applicants who have met the thirty (30) consecutive day criteria, meet all waiver criteria and wish to enter the waiver, do not have to meet the thirty (30) consecutive day criteria again if the applicant enters the waiver **within ten (10) calendar days** of discharge from the institution.

04.23.20 MAO General Hospital (Category 14) Discharged to Waiver

For an applicant not previously enrolled in a CLTC waiver who is

discharged from the hospital to a home and community-based waiver as an MAO General Hospital Category 14, a look back **is required.** Refer to Section 04.23. (An Eligibility Workflow must be created and application approved by Medicaid Eligibility.)

04.24 Institutionalization of Waiver Participant for Full Calendar Month

If a waiver participant is institutionalized for a planned, temporary stay, the case must be monitored to ensure that the stay does not exceed a full calendar month. If a participant remains in the hospital, nursing home, or rehabilitation for a full calendar month, refer to Section 05.39. Institutionalization of a waiver participant for hospice house, see section 5.40.

If a previous waiver participant is discharged to a home and community-based waiver and remains Medicaid Payment Category MAO (Category 15) , another look back for transfer of resources prior to re-enrollment is not required if the applicant enters the waiver within ten (10) calendar days of the discharge.

04.25 Medicaid Income Trusts

Medicaid Income Trusts allow an individual whose income exceeds the MAO limit to become Medicaid eligible for a nursing home (Category 10) or home and community-based waiver (Category 15), if the individual so chooses. The Medicaid Eligibility Central Processing Office is responsible for providing the applicant with information about how such trusts can be established. All eligibility criteria, including approval of the trusts by the Department of Health and Human Services' Division of Medicaid Eligibility, must be met before an applicant can be certified as Medicaid eligible.

If applicant/primary contact has questions, refer them to the Medicaid Eligibility Office.

DHHS Eligibility Division and Fiscal Division are responsible for ongoing monitoring of future cost through MMIS.

04.26 Waiver Interaction with Medicaid Managed Care (MCO)

As part of the Medicaid verification process for waiver enrollment, it must be determined through RSP that the recipient is not participating in any other special programs. If the RSP indicates an applicant is currently enrolled in an incompatible managed care plan or other waiver, the applicant/primary contact

must indicate which plan or waiver is chosen for participation. This decision should be made after all other aspects of waiver eligibility have been determined but prior to enrollment. Phoenix will not allow waiver enrollment until the RSP change is reflected in the RSP section under the Participant's Dashboard-General Information tab.

CLTC will provide the choice information to the Managed Care Division via the scdhhs.gov agency website. Once on the website, select "For Providers, then "Managed Care", then "Reference Tools" then "Waiver/Pace Enrollment". Complete and submit the information to the Managed Care Division. The information will be reviewed and the managed care staff may contact the submitter if information is incorrect. If the information is correct, the disenrollment will be retroactive to the end of the month preceding the effective date of waiver enrollment.