Slide 1:

Welcome to the Medicaid facts, fiction and updates webinar. We intend to cover several things about Medicaid in Missouri that hopefully will help you in assisting consumers. A lot of facts about it, some fiction or misinformation, and some changes that have occurred in recent years. Since 2007 Missouri has operated its Medicaid program under the name MO HealthNet, which includes not only Medicaid but also the Children's Health Insurance Program and some state only funded Medical Assistance programs.

Slide 2:

I want to start with some basics about how a person qualifies for MO HealthNet. To be eligible a person has to be in one of eight eligibility groups and meet the requirements of an eligibility category. A person has to be either age 65 or over referred to as aged, blind, have a disability, be a child under the age of 19 (or 21 if in state custody), the caretaker parent or other caretaker relative of a low-income child under 19, a woman in need of breast or cervical cancer treatment diagnosed by the Show-Me Healthy Women program, or a former foster child under age 26 who left foster care after turning 18.

Slide 3:

A person is approved for MO HealthNet by the Department Of Social Services Family Support Division, Children's Division, or Division of Youth Services based on meeting the requirements of an eligibility category. Once approved they are identified in the MO HealthNet Division system by a MO HealthNet Eligibility Code, an ME code for short. On of the things that causes confusion is that people sometimes think you have to be in a certain category or ME code to get the needed coverage or benefit package. This is in part true, but for the most part it is not accurate. There are just a few categories with very limited or restricted coverage, but most of the categories provide the same basic benefit package. Currently there are 75 ME codes in use. 6 are state only funded programs with a limited benefit package. 10 are categories with a benefit package restricted to specific services. 4 are the CHIP premium program. The remaining 55 are federally matched Medicaid categories that provide a benefit package that is not based on the category, but on whether the participant is a child, an adult, pregnant, blind or in a nursing facility.

Slide 4:

The Medicaid benefit package is a very comprehensive, it covers services that would be required for any insurance plan plus some additional services. It covers services that are not even covered by Medicare. The full comprehensive benefit package covers: primary and preventive care, hospital care, prescription medications, dental and vision care, comprehensive psychiatric rehabilitation services, substance use disorder treatment through CSTAR, home health care, non-emergency medical transportation, occupational, physical, and speech therapy, transplant services, home and community based waiver services including DMH's DD waiver services

Slide 5:

The full comprehensive benefit package is not received by everyone, but all participants in a federally matched category receive most of it unless they're in a category restricted to specific benefits. This leads to some of the confusion about what category a person needs to be in. A provider resource guide on the MO HealthNet Division's website refers to a full comprehensive benefit package for children and adults, and to adults who receive a limited benefit package, but it doesn't really explain which adults get a package that is only slightly limited versus those who get a very restricted package. The full comprehensive benefit package is for children and young adults under age 21, unless they are in the CHIP premium program or they're a child in a state only Medical assistance category. The CHIP premium program actually covers everything in the full comprehensive benefit package except non-emergency medical transportation.

Slide 6:

Adults age 21 and over in a federally matched Medicaid category based on blindness or pregnancy or who are residing in a Medicaid certified nursing facility receive a full comprehensive benefit package that covers almost all of the services covered for children. The non-covered services for adults are listed on this slide – occupational, physical, and speech therapy from an independent practice is not covered, private duty nursing is not covered, services from an independent social worker or counselor are not covered, dental care does not include orthodontics, vision care for pregnant women is limited to one eye exam per year and one pair of glasses every 2 years.

Slide 7:

All other adults get what MO HealthNet Division refers to as a limited benefit package. Which is a true statement, but also for most participants a misleading statement. It's misleading because there are only a few additional limitations, which are listed on this slide. The limitations are: dental is limited to specific services, diabetes self-management training is not covered, hearing aids are not covered, home health services do not include occupational, physical, and speech therapy, eye exams are only covered once every 2 years. Other than those services, the services covered for adults in any federally matched category are same whether or not the participant is blind, pregnant or in a nursing facility.

Slide 8:

The benefit package for the state only funded categories for Blind Pension recipients ME code 02, some children in the custody of Department of Social Services Children's Division, those in ME code 08 or Division of Youth Services those in ME code 52, state only adoption subsidy ME code 57, and some children in Group homes ME codes 64 and 65, covers all but 5 of the services in the full comprehensive package. The problem for DMH consumers is 3 of the 5 are non-covered services are DMH services. The non-covered services for the state only funded categories are CPR, CSTAR, non-emergency medical transportation, transplant services, and home and community based waiver services authorized either by the DMH Division of Developmental Disabilities or the Department of Health and Senior services.

Slide 9:

The categories that are really restricted in what they cover are those that target a specific benefit package of services to the eligibility category. These categories are QMB, the Qualified Medicare Beneficiary program, ME code 55 which only covers Medicare premiums, coinsurance and deductibles. The presumptive eligibility categories for pregnant women ME codes 58, 59, and 94 which only cover out-patient pre-natal care. The uninsured women's health services categories ME codes 80 & 89 which only cover family planning and testing for STDs, the Gateway to Better Health program (ME codes 91,92,93) which only provides coverage at participating clinics in St. Louis for preventive and wellness care, some dental care and generic prescriptions. The Missouri Rx program ME code 82 which only covers 50% of Medicare Part D prescription drug co-payments.

Slide 10

Another difference between categories is the way the coverage is received. Some categories provide all services through MO HealthNet enrolled providers that are paid on a fee-for-service basis. Other categories provide most services through a managed care plan that contracts with the MO HealthNet Division. The categories that provide all coverage as fee-for-service are those that based on being age 65 or over, blind, having a disability, receiving breast or cervical cancer treatment, or presumptive eligibility. Fee-for-service Medicaid recipients can see any provider enrolled with MO HealthNet and Medicaid will pay for the covered services.

Slide 11

Recipients in the other Medicaid categories are required to enroll in one of 3 MO HealthNet Managed Care plans, unless the recipient is eligible to opt out due to a disability and chooses to do so in order to see fee-for-service providers. The categories that require managed care enrollment are the Family Support Division's family healthcare categories for children, pregnant women, families and refugees and the Children's Division and Division of Youth Services categories for foster care, adoption subsidy, and other state custody.

Slide 12

Some services are always received on a fee-for-service basis even for recipients enrolled in a managed plan, this allows the recipient to go to any MO HealthNet provider for the service. The services that are always fee-for-service are CPR, CSTAR, prescription medications, targeted case management, transplant services, home and community based waiver services such as the DD waiver services. Also for children in state custody or adoption subsidy, all behavioral health services are covered on a fee-for-service basis.

Slide 13

This slide lists all of the MO HealthNet ME codes that do not cover DMH services, either because the category is state only funded or restricted to a specific benefit package. All of the other ME codes cover CPR, CSTAR, and DD waiver services. If you are working with a consumer that only has active coverage in one these ME codes and they need DMH services, you should assist them in applying for Medicaid most likely based on disability just like you for a consumer with no coverage. The one exception is a Blind Pension recipient in ME code 02. Since the Blind Pension program provides a cash grant of $738, if the consumer just applies for other Medicaid Family Support Division will close the cash grant before opening the other category. For Blind Pension recipients who need DMH services you should contact me so I can see if we can get FSD to do an override which would allow the consumer be in the other Medicaid category and keep receiving the cash grant.

Slide 14

Another thing that causes confusion is that Department of Social Services has 2 Divisions that are responsible for different aspects of the MO HealthNet program. The MO HealthNet Division administers the program, defines coverage, makes rules for providers, and pays claims. The Family Support Division takes applications and determines eligibility. Some of the confusion is because there are differences in how the two divisions identify the different categories. When FSD approves a person for MO HealthNet the person is assigned to an ME code which is sent to the MO HealthNet Division with the eligibility dates. Some FSD categories include multiple ME codes and some ME codes include multiple eligibility categories. This slide and the next few cover how the categories are identified by Family Support Division which is important to know since it is FSD that is determining the eligibility and doing most of the communicating with consumers. The slides also show the ME codes that are in FSD's categories. MO HealthNet for the Aged, Blind and Disabled referred to as MHABD includes the categories of spend down/non spend down, vendor nursing facility, HCB Special Income Limit group, 1619(a) & (b) status, and disabled children. Clients on MHABD are assigned to ME codes 11 if age 65 or over, 12 if blind, and 13 if disabled. The Ticket to Work Health Assurance category is ME code 85 if the client has to pay a premium, ME code 86 if non-premium. Supplemental Nursing Care provides a cash grant and Medicaid to residents of residential care, assisted living and non-vendor nursing facilities who are aged 65 or over, blind, or disabled. Supplemental Aid to the Blind provides a cash grant and federally matched Medicaid in ME code 03 to low income persons who meet Missouri's definition of blindness. The Blind Pension program ME code 02 provides a cash grant and state only funded medical assistance to blind persons with income or assets to high to qualify for supplemental aid to the blind. The MOCDD waiver or Sara Lopez waiver is ME codes 33 and 34 for children with severe disabilities who need DD waiver services.

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Old Age Assistance, Aid to the Permanently and Totally Disabled, and Aid to the Blind conversion are categories for clients who were receiving those types of cash assistance in December 1973, the month prior the start of the SSI program and would have received a lower amount of assistance under SSI. Those recipients have guaranteed conversion rights to Medicaid and a state grant to supplement their SSI. While no one not receiving in December 1973 can apply for those programs, the rules serve as the basis for the MO HealthNet for the Aged, Blind, and Disabled Medicaid category. QMB the Qualified Medicare Beneficiary program – ME code 55 only covers Medicare cost-sharing, Specified Low Income Medicare Beneficiary called SLMB or SLMB1 – has no ME code as the only benefit is payment of the Medicare Part B premium, however it is important to note that people on SLMB1 are allowed to receive Medicaid in another category if eligible. The Qualifying Individual program QI also referred to in Missouri as called SLMB2 has no ME code again as the only benefit is payment of Medicare Part B premium, the QI program is for people with income above the limit for SLMB1 and the rules are the same except that a person on QI cannot receive Medicaid, so the person who qualifies for QI and would qualify for Medicaid has choose between having the Medicare premium paid or receiving Medicaid usually as either a spend down or a Ticket to Work premium.

Slide 16

MO HealthNet for Families which includes Transitional Medical Assistance provides coverage to children under age 19 in low-income families and to their parents or other caretaker relative, the children are ME code 06, the parent or caretaker relative are 05. The MO HealthNet for Kids category covers children under 19 with family income above the MO HealthNet for Families limit but below 300% of federal poverty, it includes the CHIP premium program. MO HealthNet for Pregnant Women covers pregnant women with income not exceeding 196% of poverty and it has 5 ME codes based on different income levels and whether the woman is currently pregnant or in the 60 day post-partum period, there are no differences in coverage between the ME codes. Newborns to a woman receiving Medicaid in any federally match category are automatically covered in ME code 60 until they turn age 1. Show Me Healthy Babies provides coverage through the CHIP program to pregnant women with income above the MO HealthNet for Pregnant women limit but below 300% of poverty. Show Me Healthy Babies provides coverage until age 1 to newborns of a woman on the Show Me Healthy Babies program.

Slide 17

MO HealthNet for Women Receiving Breast or Cervical Cancer Treatment ME codes 83 and 84, this category provides full Medicaid coverage not just coverage for the cancer treatment but to qualify the cancer has to have been first diagnosed by the Department of Health and Senior Services' Show-Me Healthy women program. The Refugee Medical Assistance category provides Medicaid coverage to persons who are admitted to the United States as refugees or political asylees for the first 8 months they are in the U.S. There is a Presumptive Eligibility for Kids category, ME code 87 which provides full coverage while a final decision is being made on an application for the MO HealthNet for Kids category. There also is the Temporary MO HealthNet for Pregnant Women program called TEMP and also known as Presumptive Eligibility for Pregnant Women it covers out-patient pre-natal care while a decision is being made on an application for MO HealthNet for Pregnant Women or Show-Me Healthy Babies.

Slide 18:

There are some eligibility requirements that apply to all categories of MO HealthNet, you have to be a U.S. citizen or an eligible qualified legal immigrant, you have to be a Missouri resident which just means you are currently residing in Missouri and have no definite plans to leave. You have to provide your Social Security number you don't have to show the card just have to put the number on your application, almost all of the categories have an income limit, the exceptions are the blind pension, the breast and cervical cancer treatment program, children in state custody and former foster children.

Slide 19:

There are some eligibility factors that only apply to certain categories. Asset limits are a factor for categories for the aged 65 and over, the blind and disabled and the uninsured women's health services category. Living arrangement is a factor for persons who need Medicaid in a nursing facility or cash assistance through the Supplemental Nursing Care program. Age is factor for some categories, obviously for those that are for children, the Ticket to Work Health Assurance program also has an age limit which I'll talk about later. Uninsured, for most MO HealthNet categories a person can have other insurance, the other insurance just has to be billed prior to MO HealthNet paying, but for the CHIP premium and uninsured women's health services categories a person has to be uninsured. For the breast and cervical cancer treatment category a woman cannot have other insurance that would cover the treatment.

Slide 20:

This slide lists the current Asset limits for the categories for aged, blind and disabled persons. Currently for MO HealthNet based on OAA those aged 65 and over, PTD the disabled or AB the blind and Ticket to Work Health Assurance the available resource limits are $2,000 for a single individual and $4,000 for a married couple. Those are also the limits for the Supplemental Nursing Care program if based on blindness and the Supplemental Aid to the Blind program. The limits for the Supplemental Nursing Care program for persons based on OAA or PTD are $999.99 for an individual and $2,000 for a couple. The Blind Pension program and the Medicare cost savings programs, QMB, SLMB, QI have higher available asset limits but those programs do not cover DMH services. There is also a $560,000 home equity limit for people receiving Medicaid for care in nursing facility or in the HCB Special Income Limit category. In determining available resources, certain assets are excluded such as the person's home, at least one vehicle, and the person's monthly income. There are no asset limits for the family healthcare categories.

Slide 21

Until to July 1, 2017 the asset limits for persons receiving MO HealthNet based on having a disability or being age or 65 were $999.99 for individuals and $2,000 for married couples. Effective July 1, 2017 House Bill 1565 which passed in 2016 increased the limits to $2,000 for individuals and $4,000 for couples which are the current limits for people receiving based on blindness. The limits for the aged, blind and disabled Medicaid categories increase each July first by $1,000 for individuals and $2,000 for couples until they reach $5,000 for individuals and $10,000 for couples on July 1, 2020. After that the limits will be increased each year based on Social Security cost of living adjustment. House Bill 1565 also excludes Health Savings Accounts and Independent Living Accounts as available assets effective July 1, 2017.

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A little over 60 percent of DMH's Medicaid consumers are receiving based on disability. The definition of disability for Missouri Medicaid is the same as Social Security's definition for SSDI and SSI. The definition is that the person is not able to engage in any substantial gainful activity (SGA) which is defined as earning over $1,170 per month due to a physical or mental impairment that is expected to last for 12 months or more or could be expected to result in death

Slide 23:

If a person is receiving SSDI or SSI that establishes the disability and Family Support Division does not need any medical information to determine the disability. If a person is not receiving SSDI or SSI, a disability determination has to be made by the FSD Medical Review Team, MRT. In order to do the determination MRT needs current medical records to review. They then use the same criteria to determine the disability that Social Security uses, they just do it independently. If the basis for the disability is a mental illness MRT requires a psychological evaluation signed or co-signed by a psychiatrist or a licensed clinical psychologist. For DMH consumers in the CPR program, the comprehensive psychosocial evaluation required for enrollment in CPR is usually the best available evaluation for the MRT to use to make the disability determination. So if a person is in CPR and the community mental health center submits the psychosocial evaluation to MRT, another evaluation is usually not needed.

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Sometimes the psychosocial evaluation is completed by a qualified mental health professional other than a psychiatrist or a psychologist and signed by an advance practice nurse. MRT will still accept it if a psychiatrist or a psychologist signs a letter stating he or she has reviewed the evaluation and concurs with the findings or completes and signs FSD's Medical Report form, the IM-60A, which is available on the DMH website at the link on this slide. It's a 2 page form, but not all of the questions need to be completed as they are not necessarily pertinent to establish a disability based on mental illness. The parts that need to be completed by the psychiatrist or psychologist are, on page one answer the question about have you treated the patient and give a brief clinical history, there are only 3 lines for the history. On page 2 the psychiatrist or psychologist needs to complete the diagnosis section, listing the diagnosis, the GAF score if available, and a 2 line summary of the diagnosis. Then in the determination of incapacity section, the psychologist or psychiatrist marks that in his or her opinion the patient has or doesn't have a mental disability that prevents the patient from engaging in employment and how long the disability is expected to last. Remember that a disability has to be expected to last for 12 months or more for the person to be considered disabled. On the form this would mean the psychiatrist or psychologist needs check either 13 or more months or permanent.

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As I said to be considered disabled for SSDI or Medicaid a person cannot be engaged in substantial gainful activity, which means if the person is earning over the current SGA limit of $1,170 per month the person is not considered disabled for SSDI or Medicaid no matter what their medical condition is. However, the State of Missouri has chosen to cover an optional Medicaid category for people who are employed but have a medical condition that would meet the disability definition if they were not working. Missouri calls this category Ticket to Work Health Assurance TWHA. It uses the same definition of disability as SSDI except SGA does not apply to the determination. TWHA also allows a person with a medically improved condition to qualify. The medically improved option allows a person whose medical condition improves to the point that if being currently evaluated he or she would not meet Social Security's definition of disability, the person can still receive Medicaid as long as they still have the underlying condition. A good example of this would be a person with bi-polar disorder. When the person first goes on Medicaid the severity level of their bi-polar disorder does meet the disability definition. With treatment and medication in the CPR program the person is able to go to work earning above the SGA, but their bi-polar disorder is still severe enough that it would meet Social Security's definition of disability if they were not working so the Medicaid continues as they are still considered disabled under Ticket-to-Work. As treatment continues, the person's level of functioning later improves to the point that they would no longer be considered disabled. The person can continue to receive Medicaid in the Ticket-to work medically improved category as they still have bipolar disorder.

Slide 26

Now I want to talk about what happens when a person with a disability goes to work and how that effects their benefits, primarily their Medicaid but also SSDI and SSI. Back in 2012 we had a work group here at DMH that included Bianca, Diana, myself and 2 or 3 others and we put together a Sample Scenarios for Benefits Planning booklet that goes through the effect of going to work on eligibility for Medicaid, SSI, and SSDI for people with disabilities in 4 different situations prior to employment: A person with no income; a person only receiving SSI; a person receiving only SSDI, and a person receiving both SSDI and SSI. The Scenarios booklet is updated each year and is available on the DMH website at the link on this slide.

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When a person on Medicaid due to a disability begins employment they can end up in one of 3 different Medicaid categories depending on what their income was before employment and how much they are earning from employment. They could end up in the Ticket to work health assurance category, they could be eligible in the 1619 (a) or (b) category, or they could remain in the spend down/non-spend down category due to not qualifying for either of the other 2 categories.

Slide 28

A person receiving Medicaid based on a disability with no income prior to employment who is not earning above the SGA will continue to receive non-spend down Medicaid coverage. If the earnings are above the SGA, the person will be eligible for Medicaid in the Ticket to work category as long as their gross income does not exceed 300% of the federal poverty level which is $3,015 per month for an individual, $4,060 for a couple. SSI recipients who go to work will continue to qualify for non-spend down coverage under 1619 of the Social Security Act, even if they become ineligible for cash SSI benefits.

Slide 29

SSDI recipients receiving non-spend down Medicaid prior to employment and those with a spend down up to $50 will be eligible for Medicaid in the Ticket to work category as long as their gross income does not exceed 300% of poverty. SSDI recipients with a spend down above $50 need to earn double the amount their spend down exceeds $50 to be eligible for coverage in the Ticket to work category. For example, if the person had a $75 spend down they would have to earn $50 per month to qualify under ticket to work, a person with a $150 spend down they would have earn at least $200 per month. SSDI recipients with a spend down above $50 who do not earn enough to qualify for the ticket to work category will have their spend down amount increase by $1 for each $2 they earn above $65. SSDI recipients whose SSDI ends due to earning above the SGA will be eligible for Medicaid in the ticket to work category as long as their gross income does not exceed 300% of poverty.

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Slide 30

Before I talk more the effect of employment on Medicaid eligibility, I'm going to go over the basic budgeting for MO HealthNet for the aged, blind and disabled and how a spend down is determined. A person cannot really be ineligible for the aged, blind and disabled category due to income, they just have to meet a spend down if their income is above the non-spend down limit which is 85% of poverty $855 for single individuals, $1,151 for married couples for the aged and disabled, for people receiving based on blindness the limit is 100% of poverty $1,005 for individuals, $1,354 for couples.

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The monthly spend down amount is the amount the individual or couple's countable income after allowable deduction exceeds the non-spend down limit. If your income is $1 over you have a $1 spend down, if you're $2 over, you have a $2 spend down, if you're $300 over you have a $300 spend down. The spend down can be met either by paying it directly to the MO HealthNet Division like an insurance premium or by submitting verification of incurred medical expenses to FSD. The Mo HealthNet Division sends the client an invoice each month giving them the option. If meeting based on medical expenses FSD determines the date met which is the date coverage begins for that month and the person's liability on that date. If a person chooses to pay the spend down amount to the MO HealthNet Division and does so in advance, there is no break in the participant's coverage

Slide 32

To determine countable income, FSD deducts from gross income the first $65 of earned income, then one-half of earned income above $65, a $20 personal income exemption, all SSI payments, and health insurance premiums. Since all SSI is deducted, any SSI recipient should be eligible for non-spend down coverage.

Slide 33

Here's an example of how the spend down is calculated for a person who has income from SSDI and earnings, and would be the only way they could qualify if we didn't have the ticket to work category. The person has income of $165 from their job. First the countable earned income is determined by deducting the $65 earned income exemption and then dividing the remaining earnings by 2, leaving $50 as the countable earned Income which is then added to the person's SSDI of $1,025. Next the $20 personal income exemption is deducted leaving countable income of $1,055 since this person does not pay any Medicare or other health insurance premiums. Since the countable income exceeds the non-spend down limit of $855 by $200, the person has a $200 spend down.

Slide 34

If the person chooses to meet the spend down with medical expenses, verification of the expenses need to be sent to FSD. The expenses just have to be incurred they do not have be bills that have been paid. The client can meet the spend down by sending in bills that they have received from a provider. Or for CPR and CSTAR services, the CMHC or CSTAR provider can send FSD documentation of the cost of the services the consumer received that are billable to DMH. Those CPR and CSTAR services are allowed towards the spend down even though the consumer is not billed for them. An example of what happens when FSD receives documentation of medical expenses for a client with a $200 spend down is, FSD receives documentation of a $150 expense for a service on March 3rd from provider A, a $60 expense for a March 5th service from provider A, and an $80 expense for a March 5th service from provider B. The spend down is met on March 5th, with a $50 client liability for that date as that is the amount of the spend down met on that date. FSD then activates the coverage for March 5th through the 31st. No claims prior to March 5th will be paid, all claims for eligible services from March 6th through the 31st will be paid just like they would be for a non-spend down client. MO HealthNet Division will withhold the $50 client liability from the first March 5th claim submitted, and pay the remainder of the March 5th claims

Slide 35

This slide shows where the client should send the verification of their medical expenses if that is the way they choose to meet the spend down. The verification of the expenses can be sent to the FSD Spend Down unit by mail, fax, or scan and email.

Slide 36

Now we'll go over the requirements to qualify for the Ticket-to-Work Health Assurance Medicaid category. First the person has to have a disability. As I said earlier the disability requirement is the same as the requirement for the regular Medicaid category for the disabled, except that a person can be engaging Substantial Gainful Activity and still be considered disabled and people with a medically improved condition can also qualify. The person has to be employed at a job where Social Security and Medicare taxes are withheld or paid in the case of a self-employed person. There is no minimum amount the person has to work to be considered employed. A person has to be age 16 through 64 to qualify. This category has both a gross and net income limit, gross income cannot exceed 300% of poverty which is $3,015 for a single individual, $4,060 for married couples. The net income limit of 85% of poverty which is the same as the MO HealthNet non-spend down limit for the disabled, but there are additional income deductions. Eligible clients with gross income above 100% of federal poverty $1,005 for individuals, $1,354 for married couples must pay a monthly premium

Slide 37

The available resource limits are same as Medicaid for the disabled $2,000 for an individual, $4,000 a married couple, deposits from earnings while on the program of up to $5,000 per year to Medical savings accounts and up to $5,000 per year to independent living accounts are excluded along with the earnings on those deposits. These two types of accounts have always been excluded for TWHA but are now also excluded for the other Medicaid categories for the aged, blind, and disabled. The is no limit on the total amount that can be in the accounts, as long as no more than $5,000 is deposited in to each in any one year.

Slide 38

Now we'll go over how net income is determined for TWHA. All of the income deductions for MO HealthNet for the aged, blind, and disabled are allowed for TWHA, those are the personal income exemption, the earned income exemptions, the deduction of SSI and health insurance premiums. In addition to determine net income for TWHA all earned income of the disabled worker is deducted, and there is a standard deduction for impairment related employment expenses which is equal to half the disabled worker's earned income. So even though the person's earned income doesn't count in determining net income, the amount they earn does impact how much of their non-earned income is counted. Also $50 of SSDI is deducted, and there is a $75 standard deduction for optical and dental insurance if it the costs less than $75. If it costs more than $75, the full cost of optical and dental insurance is allowed.

Slide 39

This slide shows the premium amounts for single individuals on TWHA. There are 4 income ranges with different premium amounts. For a person with income above 100% of federal poverty but below 150%, the premium is $40. The premiums for the other ranges are $60, $101, and $151.

Slide 40

This slide shows the premium amounts for couples. Again there are 4 income ranges with different premium amounts. For a couple with income above 100% of poverty but below 150%, the premium is $54. The premiums for the other ranges are $81, $135, and $203. The premium covers both members of the couple if they are both disabled and both are employed. If only one member of the couple has a disability and is employed, the premium is the same but only that person is covered.

Slide 41

If an SSDI recipient goes to work and continues to receive SSDI, he or she will qualify for TWHA if, without the earned income, they would be a non-spend down or have a spend down of $50 or less. This is true even if they earn as little as $1 per month because if there spend down was less than $50, getting the $50 deduction of SSDI that is allowed for TWHA reduces the net income to below 85% poverty. An SSDI recipient who has a spend down above $50 has to earn double the amount the spend down exceeds $50 to qualify for TWHA on net income due to having $50 of SSDI deducted and one half of their earnings deducted from their unearned income for impairment related work expenses. The amount of earnings needed is reduced by $150 if dental/optical insurance is purchased.

Slide 42

Now back to our example of the SSDI recipient with a $200 spend down. The person would need a job paying $300 per month to be eligible for TWHA, unless dental and optical insurance are purchased. Prior to going to work their countable income was $1,055. But when they go to work earning $300, for TWHA they also get deductions of $50 of SSDI and $150 for impairment related work expenses which reduces their countable income to the net income limit of $855. The TWHA premium would be $40. This means their available income is increased by $460, $300 earned income plus $160 due to the premium being that much less than the spend down. If the SSDI recipient with a $200 spend down went to work and purchased dental and optical insurance, they would only need a job paying $150 per month to qualify for TWHA because they would get additional deductions of the $50 of SSDI and $75 for the dental/optical insurance and only need an additional $25 deduction for impairment related work expenses to reduce the countable income to $855.

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If an SSDI recipient with a spend down above $50 goes to work but doesn't qualify for TWHA as the additional deductions don't reduce the net income to below 85% of poverty, their spend down amount will increase by $1 for each $2 they earn above $65. For example if the spend down is $200, and the person gets a job paying $265 per month, the spend down will increase to $300 as their countable income goes up $100 after the earned income exemption of $65 plus one half of earnings above $65 is applied. So even though the spend down increased their available income is still $165 more than it was before they went to work.

Slide 44

With the two income limits, one that disregards earned income but gives a deduction based on the amount of earnings it can be rather confusing to figure out whether or not a person would be eligible for Medicaid under Ticket to Work. So we developed the Ticket-to-Work Health Assurance calculator which is available in various places on the DMH website. It's on the Medicaid Eligibility page that can be accessed either from the Provider Bulletin Board selection on the Mental Illness page or from the Information for Providers selection on the Alcohol and Drug Abuse page. You can also get to it on DMH Division of Behavioral Health Employment Services page, which is at the link on this slide.

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The calculator is fairly simple, by entering the amount of income the individual has if not working and the anticipated amount of earned income they would have when they go to work, the calculator will show if the person is spend down when not working along with the amount of the spend down. Then it shows if the amount of earned income will qualify the individual for TWHA and whether there will be a premium and how much it will be. If the individual does not qualify for TWHA, it shows the amount the spend down will increase to. Finally the calculator shows how much the person's available income will increase by as a result off going to work. The calculator is an excel file with 3 sheets, one for single individuals, one for married couples who both have a disability and one for married couples where only one has a disability.

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These next few slides show the calculator with an example of the determination for a single individual whose income before employment is SSDI of $1,075 per month. This slide shows the top of the sheet. In step 1 you would enter the $1,075 SSDI on line 1, in this example the person has no other unearned income so you enter zero on line 2 and they are not paying a premium for dental or optical insurance which would be entered on line 3 if they were. Also the person is not paying a premium for Medicare or other health insurance which would be entered on line 4. It is important to enter the dental and optical premiums separate from other insurance because of how they qualify for the $75 standard deduction on the TWHA budget. In Step 2 the calculator shows the total income is $1,075 and that they get a personal income exemption of $20 which is subtracted along with any insurance premiums from the total income resulting in countable income when not working of $1,055. It then shows that the person would have a $200 spend down.

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In step three of the calculator you enter the amount of anticipated earnings. There are 2 lines for earnings one for earnings from sheltered workshop employment and one for earnings from non-sheltered workshop employment including self-employment. The reason for this is that sheltered workshop income is not counted on the gross income budget, but it still qualifies the person for the impairment related employment expenses deduction from unearned income on the net income budget. In this example, the person is employed at a regular job earning $300 per month, so you enter that amount on line 9. Step 4 of the calculator shows the TWHA budget that determines the net income and whether or not the person is eligible for TWHA on net income and on gross income. If eligible on both it shows they are eligible for TWHA, if they are ineligible on either net income or gross income it will show ineligible for TWHA. In this example the calculator shows the unearned of $1,075 per month, the personal income exemption of $20, the SSDI deduction of $50, no deduction for dental and optical insurance or other health insurance, then a deduction of $150 for impairment related employment expenses which is half of the $300 earned income. The calculator subtracts these deductions from the unearned income resulting in net income of $855 which is equal to the net income limit, so the person is eligible on net income. Line 17 adds the person's unearned income and non-sheltered work shop earned income and shows they have gross income of $1,375 which is under the gross income limit and makes them eligible on gross income. The person is eligible on both net and gross, so income the calculator shows they are eligible for TWHA.

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Step 4 also shows what the TWHA premium will be for the person if they are eligible for TWHA, in our example they are eligible and the premium is $40. Step 5 shows what the spend down amount would change to due to employment for a person who is ineligible for TWHA due to either excess net or gross income.

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The final section of the calculator is labeled end result. It first delays what their available income is if they were not employed, then it shows what the available income is with the employment. In this example before employment the person had available income of $875, which is the amount of income they would have remaining from their SSDI after meeting their $200 spend down. It then shows that by earning $300 per month their available income after paying their $40 TWHA premium instead of the $200 spend down is $1,335. It then shows that their available income has increased by $460 as the result of getting a job where they earn $300 per month.

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Now let's look at what the result would be if the same person would go to work, but earn less. The information entered in steps one and two would be the same. In step 3 though the person is earning $265 per month instead of $300, so that amount is entered on line 9. Step 4 then shows that the person gets a $132.50 deduction for impairment related employment expenses which along with the other deductions reduces the net income to $872.50 as this is over the net income limit of $855, the person is ineligible on net income. So they are ineligible for TWHA even though their total income is less than in the previous example and they are under the gross income limit.

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In step 5 the calculator shows they now have a spend down of $300 rather than the spend down of $200 they had before going to work.

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The end result shows that even though the spend down is increased, the person still has more available income than before they went to work. Before going to work their available income for things other than medical expenses was $875, but after going to work their available income increases to $1,040 month which is $165 more than they had before going to work.

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Now we'll go over Medicaid eligibility based on Section 1619 of the Social Security Act which allows SSI recipients who go to work to continue to receive Medicaid, even if their SSI cash benefit ends. When an SSI recipient goes to work, the Social Security Administration determines if the person is eligible for Section 1619 status. To be eligible the person must continue to be blind or disabled, except that under 1619 the SGA requirement does not apply. This allows the SSI recipient to still be considered disabled when they go to work earning above the SGA whereas an SSDI recipient would no longer be considered disabled if their earnings exceed the SGA. For 1619 status the person has to continue to meet all SSI requirements other than earnings, for example the person's assets have to continue to be under the SSI limit. When putting a person in 1619 status Social Security has determined the person does not have sufficient earnings to replace the SSI cash benefit, their Medicaid benefits and any publicly-funded personal or attendant care services that they receive. Also Social Security has determined that they have earned income below a monthly threshold of $3,069, or a higher individualized threshold that Social Security calculates based on their individual needs. The threshold can cause confusion because FSD's policy says there is no income limit for Medicaid under Section 1619. Some people think either FSD's policy is wrong or the information about the threshold being an income limit is wrong. Actually both are true, as the threshold really is an income limit for 1619 status and everyone in 1619 status has income below a threshold. However the threshold isn't $3,069 for everyone in Missouri as Social Security can set a higher individual amount. FSD is also correct to say that there is no income limit for Medicaid based on 1619 status because FSD does not determine whether or not the person has income under the limit, if Social Security puts a person in 1619 status FSD doesn't need anything to establish that the person is eligible on income they just consider them income eligible based on Social Security's determination. All FSD needs to someone on Medicaid based on 1619 status is something from Social Security showing the person has been determined eligible for 1619(b) status, such as the letter Social Security sends the person when the their income becomes too high for them to continue to receive the SSI cash benefit. This letter will say if the person qualifies under special rules called Section 1619(b) eligibility.

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A person can receive non-Spend Down Medicaid based on 1619(b) status if Social Security puts the person in that status AND the person had MO HealthNet coverage in the month prior to gaining 1619 status.

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Disability Benefits 101 is a website that has information on health coverage, benefits, and employment for people with disabilities. It also has a calculator that shows the effect of employment on disability benefits. It is more complicated than our Ticket to work health assurance calculator in that in requires you to put in more information about the person and takes about 20 minutes or so to complete, but it allows you to put in different employment plans and shows the effect on benefits other than Medicaid. There is a link to the website on the DMH Division of Behavioral Health Employment Services web page under the Work and Benefits tab.

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Now we will go over how you can help a person get MO HealthNet coverage. When you're working with someone who isn't currently enrolled in MO HealthNet, the first thing you need to do is a screening to see if they are potentially eligible. If they are you should assist client in applying by helping them complete and submit the application to the Family Support Division. It is also very helpful if you have the client sign FSD's IM-6AR form naming yourself or someone in your organization as the person's authorized representative to apply for MO HealthNet. The authorized representative receives copies of notices sent to the client requesting additional information; a copy of the final approval or denial notice and is be able to request an appeal on behalf of the client if they are denied. It is especially important that you request an appeal or hearing if the client is denied due to being determined not disabled.

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As I said at the beginning of this presentation a person has to be in one of eight eligibility groups to be potentially eligible for Medicaid in Missouri. Two of those groups have eligibility determined based on other programs, the breast and cervical cancer treatment group based on having the cancer diagnosed by the Show Me Health Women program and the former foster children under age 26 group based on the person being in foster care when they turned age 18. To screen for potential eligibility in the other 6 groups there are 7 questions you need to ask. If the answer to any the questions is yes, then you should assist the person in applying. The questions are: 1) Is the person under age 19? 2) Is she pregnant? 3) Is the person the parent or non-parent caretaker of a child under age 19 who lives in the person's home? 4) Is the person age 65 or older? 5) Is the person receiving SSI or Social Security Disability benefits? 6) Does the person have a medical condition, other than substance use, that prevents him or her from maintaining on-going employment at this time? 7) Is the person blind? If the answer to all the questions is no the person isn't eligible. If the answer to any of them is yes the person is potentially eligible and you should assist them in applying.

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Mo HealthNet applications for the Elderly, blind, and disabled can be submitted to the Family Support Division by mail, on-line or in person. To apply by mail or on-line go the Department of Social Services web site, www.dss.mo.gov, then on the right hand side of the home page under "how do I" choose find medical coverage? , on the page it takes you to you can choose either "People with Disabilities", "Seniors", or "Blind or Visually Impaired" because the same application is used for all 3 groups. It then gives the choice to either complete and submit the application on-line; or to download an application form that can be mailed to or dropped off at any local Family Support Division resource center, the locations of the resource centers are available on the DSS web site home page. If you want to apply in-person you can do so at any Family Support Division resource center and at some hospitals and medical clinics. You can also call the FSD Information Center toll free at 1-888-275-5908 to request an application.

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DMH and FSD developed a Rush coversheet that Community Mental Health Centers, CSTAR providers, and DD case managers can use for some DMH consumers applying for Medicaid based on disability, to submit the application and if needed the MRT packet and medical records directly to the Family Support Division Processing center in Springfield. The coversheet and a flow chart for when it is appropriative to use it are available on the DMH web site Medicaid Eligibility page at the link on this slide.

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For children under the age of 19, pregnant women, and parents you can apply on-line at mydss.mo.gov OR by going to Department of Social Services web site, choosing "find medical coverage?" and then on that page choosing either "Kids", "Families", or "Pregnant Women & Newborns" and then complete and submit the application on-line. A Person can also call 1-855-373-9994 to apply or apply in person at any FSD Resource center and at some hospitals, local health departments, and medical clinics.

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If you have any questions about this presentation or if a consumer you are working with is experiencing delays or having any problems getting their application approved or has questions about why they were denied or had their Medicaid closed you can contact me by email at the address on this slide or by phone at 573-751-0342.