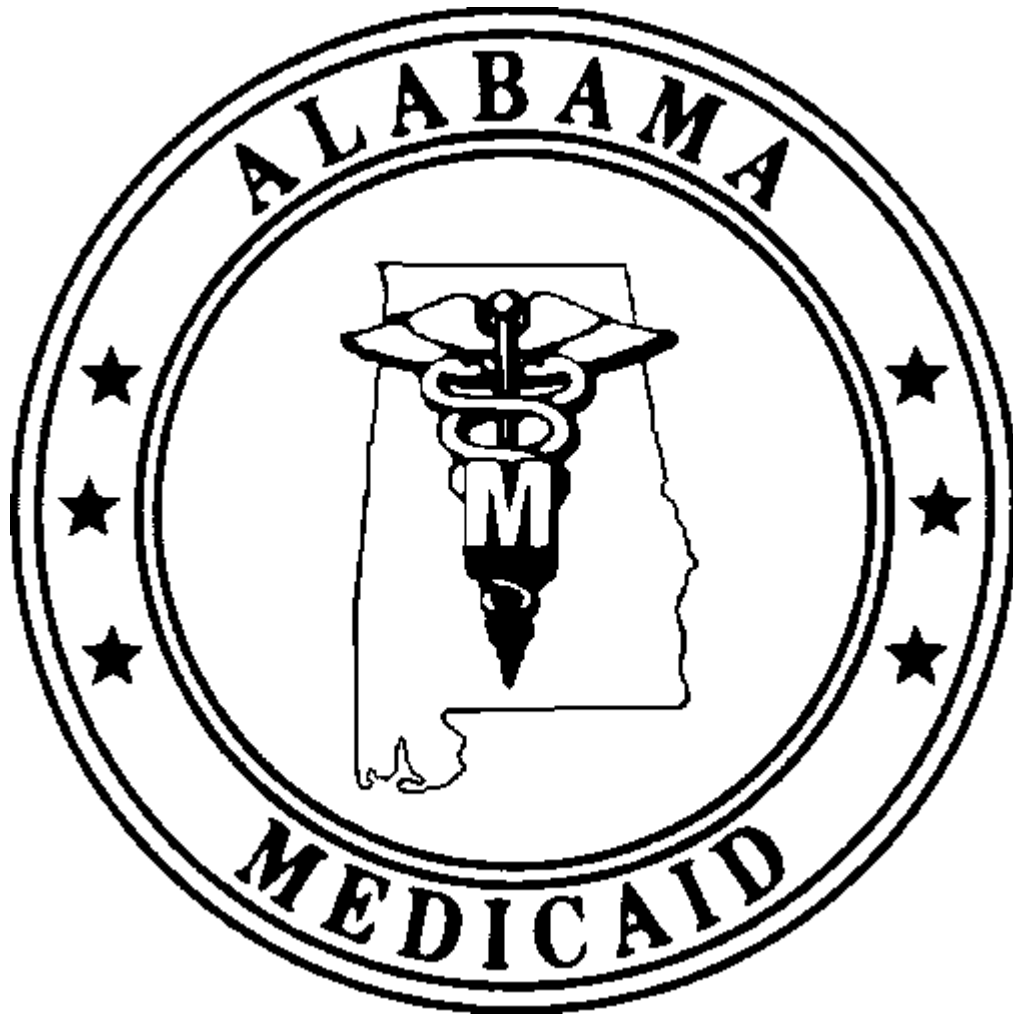


A Medicaid Primer
Alabama Medicaid Agency



July, 2009

A Medicaid Eligibility Primer

Alabama Medicaid Agency

1. What is Medicaid?

Title XIX of the Social Security Act (SSA) is a program that provides medical assistance for certain individuals and families with low income and resources. The program, known as Medicaid, became law in 1965. Medicaid is the largest program providing medical and health-related services to Alabama's poorest people.

2. Who Determines Eligibility for Medicaid Benefits in Alabama?

There are three agencies in Alabama that certify individuals for Medicaid. These agencies certify certain groups of individuals for Medicaid based on their circumstances.

These agencies are:

The Social Security Administration,
The Department of Human Resources, and
The Alabama Medicaid Agency.

The Social Security Administration certifies individuals for the following programs: Low income individuals who are aged, blind, or disabled may qualify for cash assistance through the Supplemental Security Income (SSI) program. Individuals eligible for SSI are automatically eligible for Medicaid. You may hear someone say Alabama is a Section 1634 state. That means that we accept Social Security Administration's eligibility determination for this group.

The Department of Human Resources certifies individuals for the following programs: Foster children and children who receive State or Federal Adoption Assistance.

The Alabama Medicaid Agency certifies individuals for the following programs:

Pregnant women and children under age 19. Pregnant women and children under age 19 in families with income below certain limits. Applicants should contact their local SOBRA Medicaid eligibility worker located in Health Departments and some hospitals. NOTE: Some pregnant women receive pregnancy-related services only.

Plan First Program. Women who are 19-55 years of age and whose income is below a certain limit. NOTE: These women receive family planning services only. You may call 1 (888) 737-2083 for more information.

Breast and Cervical Cancer Program. Women under age 65 who have been screened through the Centers for Disease Control and Prevention's National Breast & Cervical Cancer Early Detection Program and diagnosed with breast or cervical cancer may be eligible for this program. Call 1 (877) 252-3324.

Nursing home and institutional level of care. Medicaid District Offices certify eligibility for nursing home care, home and community based waiver services (elderly and disabled, SAIL, HIV, Living at Home, Technology Assisted, and mentally retarded, and post extended hospital days).

SSI related groups. Widow/Widower, Disabled Adult Child, Retroactive SSI, Continuous (PICKLE), Grandfathered Children.

Medicare related groups. (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiaries, Qualifying Income groups, and Qualified Disabled Working Individuals).

Emergency services for aliens- certain aliens may receive emergency services.

Medicaid for Low Income Families Program-Families with children under the age of 19 who qualify for MLIF in the household may apply.

3. Who Receives Mandatory Medicaid Benefits?

During FY 2008, 920,937 individuals were eligible for Medicaid benefits.

States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for federal funds, states are required to provide Medicaid coverage for most people who get federally assisted income maintenance payments, as well as for related groups not getting cash payments. Some examples of the **mandatory** Medicaid eligibility groups include the following:

- Limited income families with children, as described in Section 1931 of the Social Security Act, who meet the eligibility requirements in the State's AFDC plan in effect on July 16, 1996. This group is referred to as MLIF.
- Supplemental Security Income (SSI) recipients (or in States using more restrictive criteria--aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI program and which were in place in the State's approved Medicaid plan as of January 1, 1972);
- Infants born to Medicaid-eligible pregnant women. Medicaid eligibility must continue throughout the first year of life so long as the infant remains in the mother's household and she remains eligible, or would be eligible if she were still pregnant;
- Children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level and children under age 19 up to 100% of poverty. (The minimum mandatory income level for pregnant women and infants in certain States may be higher than 133%, if as of certain dates the State had established a higher percentage for covering those groups.) States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 (or such earlier date as the State may choose) in families with incomes at or below the federal poverty level. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income. States are not required to have a resource test for these poverty level related groups. However, any resource test imposed can be no more restrictive than that of the AFDC program for infants and children and the SSI program for pregnant women;
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;
- Certain people with Medicare; and
- Special protected groups who may keep Medicaid for a period of time. Some examples include persons who lose SSI payments due to earnings from work or increased Social Security benefits; and families who are provided 6 to 12 months of Medicaid coverage following loss of eligibility under Section 1931 (MLIF) due to earnings, or 4 months of Medicaid coverage following loss of eligibility under Section 1931 due to an increase in child or spousal support.

4. Which Optional Beneficiary Groups May Receive Medicaid Benefits?

States also have the **option** to provide Medicaid coverage for other "**categorically needy**" groups. These **optional groups** share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. Examples of the optional groups that States may cover as categorically needy (and for which they will get federal matching funds) under the Medicaid program include the following:

- infants up to age one and pregnant women not covered under the mandatory rules whose family income is below 185 percent of the Federal poverty level (the percentage to be set by each State); **(Alabama does not utilize this option)**
- optional targeted low income children; **(AL does not utilize this option)**
- certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level; **(AL does not utilize this option)**
- children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible for AFDC; **(AL utilizes this option for DHR state foster children and DYS children)**
- institutionalized individuals with limited income and resources; **(AL utilizes this option and covers up to 300% of the SSI income level)**
- persons who would be eligible if institutionalized but are receiving care under home and community-based services waivers; **(AL utilizes this option for the MR, E&D, SAIL, and other waivers)**
- Recipients of State supplementary payments; **Alabama does not utilize this option.** However, Alabama covers certain individuals who once received SSI and supplemental payments.
- TB-infected persons who would be financially eligible for Medicaid at the SSI level (only for TB-related ambulatory services and TB drugs) **(Alabama does not utilize this option);**
- low-income, uninsured women screened and diagnosed through a Center's for Disease Control (CDC) Breast and Cervical Cancer Early Detection Program (NBCCEDP) and determined to be in need of treatment for breast or cervical cancer. **(AL utilizes this federal option which is now a state law)**

States may use more liberal income and resources methodologies to determine Medicaid eligibility for certain AFDC-related and aged, blind, and disabled individuals under Sections 1902(r)(2) and 1931 of the Social Security Act. For some groups, the more liberal income methodologies cannot result in the individual's income exceeding the limits prescribed for Federal matching.

5. Does Medicaid Cover All Low-Income People?

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the designated mandatory groups or in an optional group the state has elected to cover.

Low income is only one test for Medicaid eligibility; assets and resources are also tested against established limits in most programs. Categorically needy persons who are eligible for Medicaid may or may not also receive cash assistance from the TANF program or from the SSI program. Additionally, states define in their State Plan, the amount, duration, and scope of coverage. State Medicaid Agencies may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. A State Plan must provide that the services available to any individual in the categorically needy group are equal in amount, duration, and scope for all recipients within the group.

6. What is the Medicaid - Medicare Relationship?

The Medicare program (Title XVIII of the Social Security Act) provides hospital insurance (HI), also known as Part A coverage, and supplementary medical insurance (SMI), also known as Part B coverage. Coverage for HI is automatic for persons aged 65 and older (and for certain disabled persons) who have insured status under Social Security or Railroad Retirement. Coverage for HI may be purchased by individuals who do not have insured status through the payment of monthly Part A premiums. Coverage for SMI also requires payment of monthly premiums. Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from their State Medicaid program. These "dual eligibles" are entitled to Medicare and are eligible for some type of Medicaid benefit.

For persons with full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their State's Medicaid program. Services that are covered by both programs will be paid first by Medicare and the difference by Medicaid, up to the State's payment limit. Medicaid also covers additional services (e.g., nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids).

Limited Medicaid benefits are also available to pay for out-of-pocket Medicare cost-sharing expenses for certain other Medicare beneficiaries. The Alabama Medicaid program will assume their Medicare payment liability if they qualify. Qualified Medicare Beneficiaries (QMBs), with income at or below 100% of the annual Federal poverty level (FPL), do not have to pay their monthly Medicare premiums, deductibles, and coinsurance. Alabama dropped the resource/assets test for QMBs. Specified Low-Income Medicare Beneficiaries (SLMBs), with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120% of the FPL, do not have to pay the monthly Medicare Part B premiums. Qualifying Individuals (QIs), who are not otherwise eligible for full Medicaid benefits and with resources at or below twice the standard allowed under the SSI program, will get help with their monthly Medicare Part B premiums, depending upon their income. Each state has a limited number of slots for QI's.

Individuals who were receiving Medicare due to disability, but have lost entitlement to Medicare benefits because they returned to work, may purchase Part A of Medicare. If the individual has income below 200% of the FPL and resources at or below twice the standard allowed under the SSI program, and they are not otherwise eligible for Medicaid benefits, they may qualify to have Medicaid pay their monthly Medicare Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

7. How Much Does Medicaid Pay for the Medicare Premium Buy-In Program?

Through the Buy-In Program, Medicaid pays Medicare Part A and B premiums for eligible Medicaid recipients. In fiscal year 2008, Medicaid paid over \$8.4 million in Part A premiums for approximately 1,839 individuals; and over \$218 million in Part B premiums for approximately 214,762 individuals. For recipients eligible for the Qualified Medicare Beneficiary (QMB) Program, Medicaid may also cover their Medicare co-insurance and deductibles. For more information about the Buy In program, contact Wanda Wright at (334) 242-5281.

8. Who are Alabama's Medicaid Providers?

Any physician or dentist who is licensed by their State License Boards may become a Medicaid provider. Alabama Medicaid's fiscal agent, EDS, processes applications. Primary care physicians provide medical homes for patients through the Patient 1st program and most primary care physicians in Alabama are enrolled in Medicaid. Physicians taking part in the Medicaid program are designated as serving in rural or urban communities. Each year, more than 600,000 Medicaid patients receive care from a physician and that care is provided by 5,000 physicians, 75% of whom practice in urban areas.

Alabama dentists have become more involved in the Medicaid program in the last few years with renewed interest in being available to Medicaid children. As of October 2008, 813 dentists were enrolled in the program. The Agency expects enrollment to continue to expand. Additionally, the number of counties with only one or no dentist enrolled has decreased from 11 to 8.

9. How Does Medicaid Watch for Fraud?

The Medicaid Alliance for Program Safeguards is committed to fighting fraud and abuse, which divert dollars that should be spent to safeguard the health and welfare of Medicaid clients. States are primarily responsible for policing fraud in the Medicaid program. Fraud schemes often cross State lines. Through the development of the Medicaid Fraud Statutes website and leadership, the Medicaid Alliance for Program Safeguards works to build partnerships and cooperative efforts among State Medicaid programs, State Program Integrity Units, State Quality Control Units, State Surveillance and Utilization Review Units, State Medicaid Fraud Control Units, the Department of Health and Human Services' Office of Inspector General, the Federal Bureau of Investigation, and the Department of Justice, among other partners.

We are all partners, however, in fighting fraud and abuse in Medicaid. Suspected beneficiary or provider fraud may be reported toll free at (800) 362-1504.

10. Who Does Medicaid Cover?

Medicaid covers over 930,000 individuals. Individuals generally become eligible through one of the federally mandated programs and sometimes through a federally optional program that Alabama has opted to cover.

This is a very condensed summary of the different eligibility programs covered by the Alabama Medicaid program:

ELIGIBILITY GROUPS SUMMARY-ALABAMA MEDICAID AGENCY

Eligibility Group	Includes	Federal Requirement	Meets or Exceeds or Optional Program
NURSING HOME/ INSTITUTIONALIZED	Nursing home; extended hospital awaiting nursing home placement; facilities for the mentally ill or retarded	The 2009 nursing home income limit is \$2,022	Exceeds. AL covers institutionalized individuals with income up to 300% of the SSI income level. This option is known as the 300% of SSI rule. Resources are within the SSI resource limit. As required by law, AL covers individuals who establish a Qualifying Income Trust.
SSI-RELATED	Widow/Widower; Disabled Adult Child; Grandfathered Cases; continuous (PICKLE); retroactive SSI; children of SSI mothers	Income guidelines set annually at federal level. 2009 SSI income limits at \$694 for individual and \$1,031 for couple.	Meets minimum federal requirements. AL does not utilize the option to cover optional supplementary payment groups. AL does not utilize the OBRA 86 option for aged and disabled persons with incomes up to 100% of the FPL.
MEDICARE-RELATED	Qualified Medicare Beneficiaries; Specified Low Income Medicare Beneficiaries; Qualifying Income Individuals, and Qualified Disabled Working Individuals	FPL as of 02/2009 QMB-income below 100% FPL (\$923 – individual; \$1,235 - couple); SLMB-income between 100%-120% FPL (\$923.01-\$1,103.00 – individual; \$1,235.01 - \$1,477.00 - couple); QL-1-between 120%-135% (\$1,103.01-\$1,239.00 – individual; \$1,477.01 - \$1,660.00 - couple) QDWI- income under \$1,825.00 – individual; \$2,449.00 – couple	Meets minimum income requirements. However, AL applies less restrictive methodology. Fluctuating income may be averaged for the past six months and projected for 12 months; in-kind support and maintenance is not counted as income; interest and dividend income is not counted in determining eligibility; and all resources are disregarded.
PREGNANT WOMEN AND CHILDREN	Pregnant women and children under the age of 19	Covers children under age 6 and pregnant women with family income below 133% of the FPL; and children age six but under age 19 (6-18) up to 100% of the FPL.	Meets minimum income requirements for pregnant women and children under age 19. Infants born to Medicaid eligible pregnant women have coverage through the first year of life. AL does <u>not</u> utilize option to cover family income up to 185% of the FPL. AL does not impose optional assets/ resource test.
MEDICAID FOR LOW-INCOME FAMILIES	Low income families with children	Section 1931 of the SSA who meet eligibility requirements in the State's AFDC plan in effect on July 16, 1996.	Meets federal income requirements but is well below the national average. Covers only the poorest of the poor (11.5% of FPL).
OPTIONAL FEDERAL CATEGORIES	Breast and Cervical Cancer Program; State of AL Independent Living (SAIL) waiver; MR waiver; E&D waiver; OBRA waiver; Plan First waiver, Technology Assisted waiver for Adults, HIV/AIDS waiver	AL utilizes option 1915 (c) of the SSA to cover individuals who meet the institutional level of care but desire to remain at home and receive care under the SAIL waiver, MR waiver, E&D waiver, Technology Assisted waiver for Adults, and HIV/AIDS waiver.	The federal optional Breast and Cervical Cancer Option was passed into AL law as a mandated service. The Home and Community Based Waivers are optional services that provide a cost savings to the agency. Otherwise these individuals would be in more costly nursing home settings. The Plan First optional waiver continues to be a cost effective waiver by reducing costs for unplanned pregnancies.
ALL OTHER	Emergency Services for Aliens; Department of Youth Services Children; DHR Foster Children; Adopted Children; Refugees etc.	Title IV-E covers adoption and foster care	AL meets requirements for aliens ER services. AL does not utilize option to cover TB infected individuals. AL utilizes option to cover certain children (state foster children) up to age 21 who meet income and resource requirements for AFDC and have special medical needs. Refugee services are 100% reimbursed by the refugee resettlement program.

11. Please Summarize the Eligibility Policy for the Elderly and Disabled.

Cash Assistance Group

- Alabama is a Section 1634 state. We accept the Social Security Administration's eligibility determination.

State Supplement Group (Optional Group)

Many states supplement the basic SSI cash assistance with state supplementary payments (SSP) to certain SSI beneficiaries (who receive the SSI payment plus the SSP) and people with incomes too high to qualify for SSI (only receive the SSP). Financed solely with state money, these payment amounts vary widely from state to state. States can opt to make anyone receiving an SSP automatically eligible for Medicaid; at least thirty-five states have elected this option. States may also apply less restrictive methodologies to this group when determining how to count income and resources.

- Individuals receiving State Supplemental payments (SSP) are automatically eligible to receive Medicaid in Alabama.

Dual Eligible Group

Described in the Medicaid-Medicare Relationship, question 6.

- Alabama applies the following less restrictive income methodologies for this group: Fluctuating income may be averaged for the past six months and projected for twelve months; in-kind support and maintenance (ISM) is not counted as income; interest income is not counted in determining eligibility; dividend income is not counted in determining eligibility. All resources are disregarded (no asset test).

Institutionalized Individuals (Optional Expansion)

Congress gave states the option to use the special income rule to provide Medicaid to persons in institutions who have too much income to qualify for SSI benefits, but not enough income to cover their expensive long-term care. Under the special income rule, also known as the 300% of SSI rule, states may set a special income standard up to 300% of the maximum SSI benefit. This applies to gross income only—that is, there are no exclusions or deductions. Resource standards are generally the same as those in the SSI program. The special income rule was originally limited to persons in institutions, but now states may elect to apply it to those receiving services under home and community-based care (HCBS) waivers, as well. Both groups—persons in institutions and persons under HCBS waivers—are required to incur a post-eligibility cost-sharing burden under this eligibility category. States that use the special income rule, but do not offer a medically needy group for aged, blind, and disabled persons must allow the use of Qualifying Income Trusts (QITs) also known as Miller Trusts—a trust designed to hold and apportion the individual's excess income according to need and for the express purpose of becoming eligible for Medicaid, subject to Medicaid estate recovery. States must allow nursing facility residents to keep a limited amount (at least \$30) of their income as a personal needs allowance. Some states have opted to increase this amount slightly. Each state also has spousal impoverishment protections in place to ensure that when one spouse is institutionalized for at least 30 days, the other spouse—the community spouse—does not lose all income and resources,

thereby becoming impoverished and needing public assistance. The community spouse's income is not considered available to the institutionalized spouse.

To protect resources, the couple's resources (excluding home, household goods, one automobile, and burial funds) are combined and then halved to determine the spousal share. The spousal share is then compared to the state's community spouse protected resource amount (CSRA). The amount actually protected for the community spouse is the greater of either the spousal share or the CSRA. By federal law, the CSRA is subject to a minimum (at and below which the entire amount is protected) and a maximum. When setting its CSRA, the state may exceed the federally prescribed minimum, but may not exceed the federal maximum.

- Alabama uses the special income standard for institutionalized individuals.
- The special income standard is at 300% of SSI income for a month.
- The monthly personal needs allowance for nursing facility residents is \$30 per individual in nursing home. (Veterans or widows of veterans with no dependents may receive \$90.00 VA benefit payment while in the nursing home for personal needs allowance.)
- Alabama uses an amount in the middle as its minimum community spouse protected resource standard. Our minimum community spouse protected resource standard is \$25,000. We allow the federal maximum community spouse protected resource of \$109,560.

Home and Community-Based Waiver Services (Optional Group)

States may apply for §1915(c) home and community-based care waivers that allow them to extend Medicaid eligibility to those at risk of institutionalization who wish to remain in a community setting. Under this waiver authority, a state may provide a wider range of long-term care services than is generally allowed under the state's Medicaid program, including non-medical services such as minor home modifications like ramps or special safety devices. Often states operate several HCBS waivers targeted to various populations.

Applicants must still qualify for Medicaid under one of the Medicaid eligibility groups and must require a nursing home level of care. However, many states link financial eligibility for their HCBS waivers to a percentage of the maximum monthly SSI payment (often via the special income rule), a percentage of the federal poverty level, or their medically needy income level.

States may apply spousal impoverishment rules to HCBS waiver participants, similar to the protections guaranteed to institutionalized persons.

States may choose to allow spend-down to HCBS waiver eligibility levels. If a state uses the special income rule and does not allow spend-down to HCBS eligibility levels, it may allow Qualifying Income Trusts (Miller Trusts) in determining eligibility for HCBS waivers.

Because waiver participants must cover all of their living expenses themselves, states that extend the special income rule to HCBS often allow them a significant personal needs allowance. In addition, states may offer a monthly maintenance needs allowance for a spouse.

- Alabama uses different income standards for its HCBS waivers.
- Income eligibility for HCBS waivers is tied to:

- 300% federal benefit rate for SAIL, HIV/AIDS, TA, MR and the Elderly and Disabled waivers.
- Alabama does not allow spend-down to HCBS waiver eligibility levels.
- Alabama does not allow Qualifying Income Trusts (Miller Trusts) in determining eligibility for HCBS waivers.
- Alabama's protected monthly income for individuals receiving HCBS varies by waiver: The SAIL, HIV/AIDS, TA, MR and the Elderly and Disabled waivers protect 300% of the federal benefit rate.
- Alabama's monthly maintenance needs allowance for a spouse (other than spousal impoverishment rules) is none.
- In, Alabama, none of the waiver participants incur a post-eligibility cost-sharing burden or liability.

12. Please Summarize the Eligibility Policy for the Women's and Children's Groups.

Pregnant Women and Children (Mandatory Group)

In 1986, Congress enacted legislation allowing states, for the first time, to expand eligibility for Medicaid without expanding eligibility for Aid to Families with Dependent Children (AFDC). This federal law was called the Sixth Omnibus Budget Reconciliation Act (SOBRA). Subsequently, other federal laws have been enacted mandating coverage to even more children and pregnant women and mandating the outstationing of social workers in disproportionate share hospitals and health centers for easy access to the program by potential clients. In 1997 Congress passed the Balanced Budget Act. This legislation created the Title XXI Child Health Insurance Program (CHIP). The same legislation allowed for Continuous Medicaid Eligibility for all children determined eligible April 1, 1998 or thereafter.

- In July 1988, Alabama enacted this legislation to provide Medicaid coverage to pregnant women and children with income at or below the required Federal Poverty Level.
- Alabama has 180 SOBRA workers outstationed in hospitals, health department clinics and other health centers.
- Alabama was the first state in the nation to implement CHIP through a Medicaid expansion on February 1, 1998.
- Pregnant women and children under age six must have family income at or below 133% of the federal poverty level
- Children age six to 19 must have family income at or below 100% of the federal poverty level
- Family assets are not counted for eligibility.
- Parental income is not counted for pregnant women who only desire to receive pregnancy related services
- Pregnant women, once determined eligible, remain eligible through sixty days post-partum

- Children born to Medicaid eligible pregnant women remain eligible for one year without separate application or verification
- Children under age 19, once determined eligible, remain continuously eligible for 12 months as long as they reside in the state.
- Pregnant women may be eligible to receive full Medicaid services through their sixty days post-partum if they meet Medicaid for Low Income Families income standards
- Income for a child in the home is not counted toward the eligibility of a pregnant woman or another child
- Income of a step-parent is not counted toward the eligibility of a child in the home
- Related or non-related caretakers may apply for a child
- Income of caretakers other than legal parents is not counted toward the eligibility of a child
- Application may be made in-person, by mail or on-line, and you may apply in any county

Medicaid for Low Income Families Qualified Pregnant Women ((MLIF-Q)

Certain pregnant women may qualify for full Medicaid coverage. If the claimant meets Medicaid for Low Income Families (MLIF) program requirements, she may choose to receive full Medicaid coverage instead of coverage for only pregnancy related services normally covered through the SOBRA program. In addition to SOBRA requirements, the claimant must meet the following requirements in order to qualify for full coverage:

- Gross monthly income must fall below Medicaid for Low Income Families income limits.
- If the pregnant claimant is under age 18 and is living in the home with her parent(s), the amount of deemed income must not exceed MLIF income limits.

Plan First (Optional Waiver for Family Planning Services)

The Plan First waiver extends Medicaid eligibility for family planning services to all women of childbearing age (ages 19 through 55) with incomes at or below 133% of the federal poverty level that would not otherwise qualify for Medicaid coverage.

Under existing Medicaid Programs, adult women and teenage girls are covered for family planning services along with all other Medicaid services through the Medicaid for Low Income Families (MLIF) program, the SSI program or other categorical eligibility groups. Women who receive Medicaid coverage for pregnancy and delivery services through the SOBRA program are covered for family planning services until the end of the month in which the 60th postpartum day falls. Women served through Plan First will be able to take advantage of all family planning services that are offered through the Alabama Medicaid Agency and will be able to receive these services directly through any qualified provider enrolled in the Plan First Program.

Breast and Cervical Cancer Program (Optional Eligibility Group)

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) allows states to provide full Medicaid benefits to uninsured women under age 65 who are identified through the Centers for Disease Control and Prevention's National Breast

and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer. This includes pre-cancerous conditions of the breast or cervix and early stage cancer.

- The Alabama Legislature passed the Breast and Cervical Cancer Prevention and Treatment Act of 2000, requiring the federally optional program to be implemented in Alabama. Effective October 1, 2001, the Alabama Medicaid Agency extended full coverage Medicaid eligibility to females under age 65 who have been screened by the Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) and been found to need treatment for breast or cervical cancer. In Alabama, the CDC funded program is administered through the Alabama Department of Public Health.

13. What are the Mandatory Services for Categorically Needy Medicaid Beneficiaries?

Mandatory Services are defined at 42 CFR 440.210. References below are from 42 CFR or the SSA. Mandatory services are:

Inpatient hospital services other than services in an institution of mental disease 440.10

Outpatient hospital services 440.20(a)

Federally Qualified Health Centers 1905 (a)(2)(C) of the SSA

Rural Health Clinic services 440.20(b)

Other laboratory and X-ray services 440.30

Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease) 440.40(a)

Early Periodic Screening, Diagnostic, and Treatment (EPSDT) 440.40(b)

Family planning services and supplies 440.40(c)

Physician services 440.50(a)

Medical and surgical services of a dentist that if provided by a physician would be considered physician's services 440.50(b)

Home health services including nursing, aide, and therapy services provided by a Home Health Agency in the home; and medical supplies, equipment and appliances suitable for in-home use 440.70

Nurse midwife services 440.165

Nurse practitioner services 440.166

Pregnancy related services including postpartum 440.210

14. Which Services are Optional for Categorically Needy Medicaid Beneficiaries?

*Clinic services-preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital 440.90

Critical Access Hospital (CAH) services 440.170(g)

Dental services-diagnostic, preventive and corrective procedures 440.100

Dentures 440.120(b)

*Diagnostic, screening, preventive, and rehabilitative services 440.130

Emergency Hospital services even if the hospital does not meet the conditions of participation for Medicare or the definitions of 440.170(e)

- *End Stage Renal Disease 441.40
- *Eyeglasses 440.120(d)
- *Home and Community Based services 440.180/440.181
- *Hospice services 1905(o) of the SSA
- *ICF-MR facility services 440.150
- *Inpatient hospital services, nursing facility services, or intermediate care facility services for individuals age 65 or older in institutions for mental disease 440.140
- Inpatient psychiatric services under age 21 440.160
- Medical or other remedial care provided by licensed practitioners other than physicians within the scope of practice defined by State Law such as chiropractic services 440.60
- Occupational therapy 440.110(b)
- *Organ transplants 441.35
- Personal care services 440.167
- Physical therapy 440.110(a)
- *Prescribed drugs 440.120(a)
- *Primary care case management services 440.168
- Private duty nursing services 440.80
- Prosthetic devices 440.120(c)
- Respiratory care for ventilator dependent individuals 440.185
- Services for individuals with speech, hearing and language disorders 440.110(c)
- Skilled nursing facilities for individuals under age 21 440.170
- *Targeted Case Management services 1905(a)(19) or 1915(g) of the Act
- *Transportation 440.170

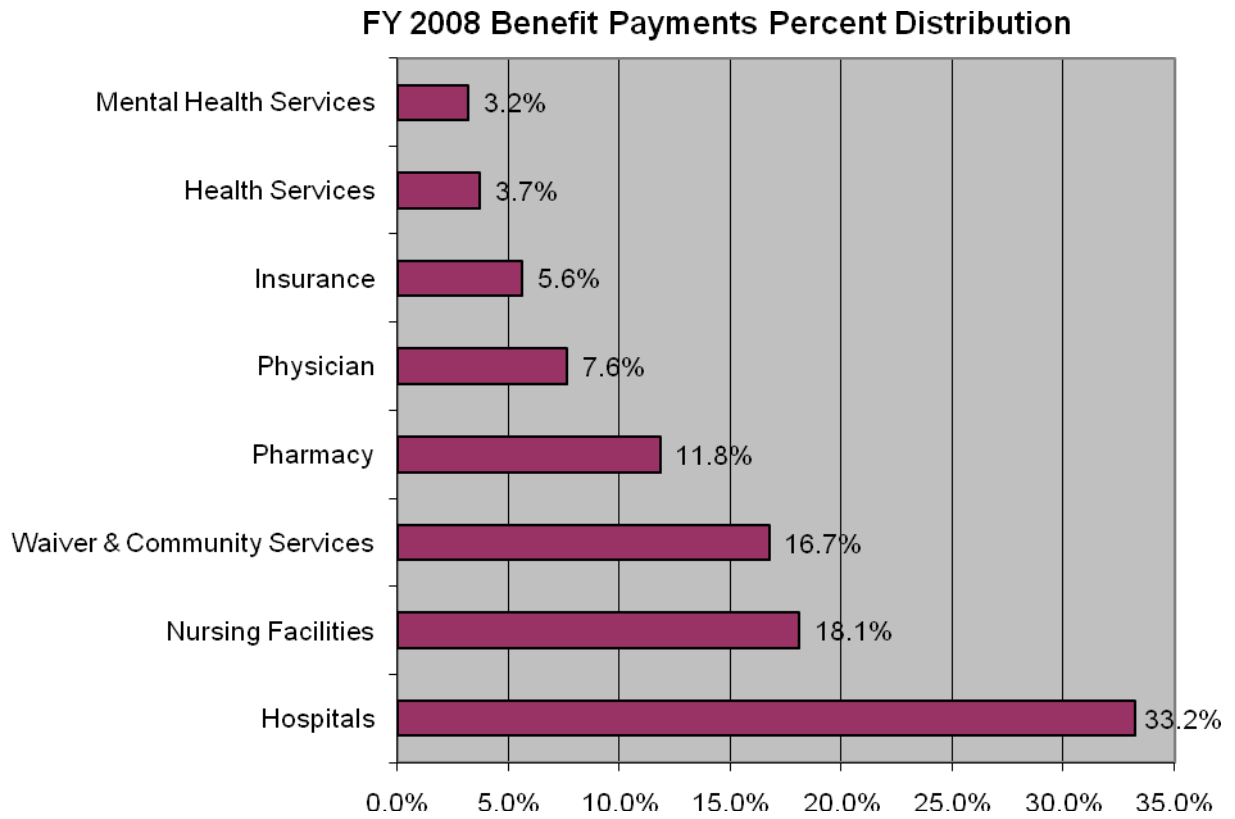
*Indicates the optional services covered by Alabama Medicaid for adults under the State Plan. QMBs receive additional coverage if Medicare makes payment.

15. How is Medicaid Funded?

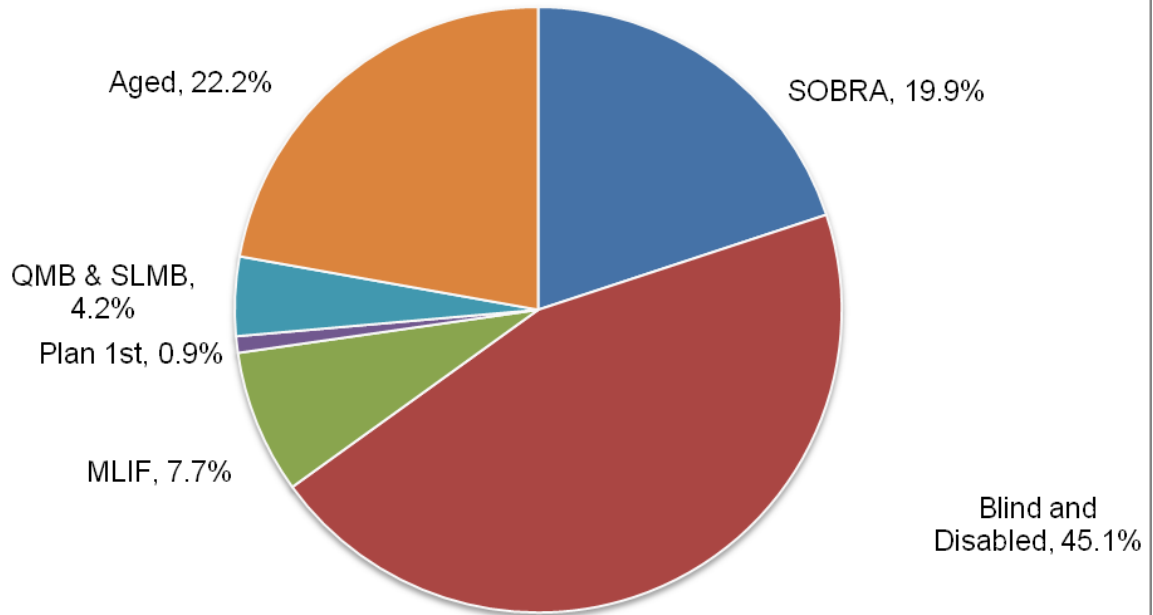
The Federal and State governments jointly fund Medicaid. To be eligible for federal funds, states are required to provide Medicaid coverage for mandated coverage groups.

The FY 2009 approved budget is \$4.5 billion. This includes the state and federal share. Alabama Medicaid has one of the lowest administrative costs in the nation at 3 percent. Medicaid strives to place every possible dollar into use for direct medical services to beneficiaries thereby decreasing administrative costs associated with salaries, overhead and activities such as outreach. Medicaid outreach activities are often funded through grants Medicaid has procured in order to save budget dollars for direct medical services. Since the federal administrative match is lower for outreach than for actual medical service benefits and Medicaid funding is constrained, Medicaid judiciously uses its funding almost exclusively for the direct medical care of its beneficiaries. Very few public or private organizations have as cost-effective administration as the Alabama Medicaid Agency. For additional information on administrative costs, contact our Chief Financial Officer, Terry Bryant at (334) 242-2301.

16. Where is the Money Spent?



FY 2008 Benefit Payments by Category of Aid



17. How does Alabama Medicaid Reimbursement Compare to Other Insurers?

In January 2006 rates were increased again for certain physician and dental services. CPT coded office visit reimbursement is currently at 87 percent of Medicare rates; while other medical procedures are paid at 70 percent of Medicare. EPSDT rates are above Blue Cross PMD rates and children's specialty clinic services are based upon actual cost. For more information on provider reimbursement rates, contact Kathy Hall at 334.242.5007.

18. What Has Medicaid Done to Streamline the Eligibility Process?

The Medicaid Agency has been at the forefront in regard to streamlining the eligibility process since outstationing began in 1991. Medicaid immediately eliminated the requirement for a face- to face- interview; instituted a mail-in application; and implemented an expedited newborn eligibility process. Since 1991, Medicaid has excluded resources for pregnant women and children and eliminated the deeming of parental income for pregnant women under age 19. When welfare reform was implemented, the agency chose to provide coverage to the optional group of Lawful Permanent Resident Aliens who were living in the United States before 8/22/96. During the time of the implementation of the CHIP program, Medicaid considered 12 months continuous eligibility, and implemented it in April 1998 for all Medicaid eligible children under 19. This was prior to the implementation of the ALL KIDS program. As part of a continuing campaign to streamline eligibility, Medicaid also dropped the assets test for QMB and SLMB eligibles in July of 1998 and has instituted passive reviews for some eligibility groups. Prior to our Covering Kids Pilot project Medicaid had initiated a pilot project in Jefferson County to eliminate the interview at the Medicaid annual review. When the Covering Kids grant was awarded, Medicaid took the opportunity to continue our exploration of streamlining possibilities by eliminating the interview in one county, eliminating the age verification in one county, and eliminating the income verification in one county. In May of 2001 Medicaid further streamlined by eliminating age verification, accepting self-verification of application for other benefits and accepting self-declaration of child care expenses statewide for pregnant women, children under 19 and Family Planning recipients. Medicaid also instituted self-declaration of income in all three pilot counties. Unfortunately the error rate on self reported income exceeded the percentage allowed by CMS and Medicaid discontinued that portion of the pilot. Currently the Department of Public Health's ALLKids program, Medicaid, and the Blue Cross Child Caring Program use one single application for services. Income determines which program the applicant receives. Medicaid's renewal form can be used to refer claimants from Medicaid to ALLKids or vice-versa. The Alabama Medicaid Agency continues to look at program improvements that are administratively efficient as well as cost effective. For more information on our streamlining efforts, contact Gretel Felton at (334) 242-1720.

Medicaid has a Training Unit established for the purpose of providing and coordinating eligibility training and enrollment outreach. Ricky Hatcher heads up that unit and may be reached at (334) 242-1734.

19. How is Medicaid a Value to the State?

Since its inception, Medicaid has had a significant impact on the overall quality of health care in the state. Medicaid has provided over two million citizens access to quality health care they could not otherwise afford. Health care is one of the states most important industries and Medicaid contributes to that industry in a significant way. For instance, during FY 2008, Medicaid paid \$4.2 billion to providers on behalf of persons eligible for the program. Matched at approximately 68% by the federal government, these funds paid the salaries of thousands of health care workers who bought goods and services and paid taxes in Alabama. Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation at 3% for FY 2008. With the current administrative rate of approximately 3% of the Agency's budget goes toward purchasing services paid directly to the providers who treat Medicaid beneficiaries.

Glossary of Eligibility Terms:

1634 state – state that relies on the Social Security Administration to determine Medicaid eligibility for the SSI beneficiaries in their state

209(b) state - state that opted to continue to use the Medicaid eligibility standards it had in place when SSI was enacted in 1972. Those policies are generally more restrictive than the SSI eligibility rules

300% of SSI rule – another name for the special income rule

ABCCEDP - Alabama Breast and Cervical Cancer Early Detection Program

BCCPTA - Breast and Cervical Cancer Prevention and Treatment Act of 2000

CDC - Centers for Disease Control

CHIP - Child Health Insurance Program

CMS - Centers for Medicare and Medicaid Services formerly known as the Health Care Financing Administration

Community spouse – community-dwelling spouse of an institutionalized person

Community spouse protected resource amount – amount to which the spousal share is compared for protection against spousal impoverishment. The amount actually protected for the community spouse is the greater of either the spousal share or the CSRA.

Continuous Medicaid - 12 months of eligibility for children under the age of 19 unless the child moves out of state, dies, or requests termination.

Countable – amount of income or resources left after applying all eligibility methodologies

Dual eligibles - individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit

Income standard - the maximum amount of income a person can have and still be eligible

Title IV-E - the section of the Social Security Act that addresses federal payments to states for foster children and adoption assistance

Methodology - process used to determine a person's countable income or resources, which are then compared against the appropriate standard

MLIF - Medicaid for Low-Income Families

MLIF-Q - Medicaid for Low Income Families, Pregnant Women

Personal needs allowance – limited amount of income a nursing facility resident is allowed to keep for monthly expenses

Qualifying Income Trust (Miller Trust) - trust designed to hold and apportion the individual's excess income according to need and for the express purpose of becoming eligible for Medicaid, subject to Medicaid estate recovery

Resource standard - the maximum amount of resources a person can have and still be eligible

Retroactive coverage - claimant's eligibility will begin the first day of the third month prior to the month of application; if the claimant was eligible in that month and the claimant received medical services of a type covered by Medicaid in that month. Some programs such as QMB do not have retro coverage

Special income rule – state option to provide Medicaid to persons in institutions who have too much income to qualify for SSI benefits, but not enough income to cover their expensive long-term care payments such as care in a nursing home

Spousal impoverishment protections – process designed to ensure that when one spouse is institutionalized for at least 30 days, the other spouse does not lose all income and resources, thereby becoming impoverished and needing public assistance

Spousal share – amount determined when the couple's resources (excluding home, household goods, one automobile, and burial funds) are combined and then halved up to the federal maximum for the spousal impoverishment protection

SSI criteria state – state that requires SSI beneficiaries to file a separate Medicaid application with the state, which allows the state itself to determine eligibility for Medicaid (also called a 209b state)

State supplementary payments – amount by which a state may opt to supplement the basic SSI cash assistance

Supplemental Security Income – cash benefit available under Title XVI of the Social Security Act to certain persons who are aged, blind, or disabled and whose income and resources fall below the SSI standards set by the federal government

