"Please stand by for realtime captions." >> [Captioner standing by] >> Good morning everyone and welcome to this Family Connection SC webinar. We will get started very soon . We will be starting shortly. >> >> We are just about ready to start the webinar . If you can, please mute your phone. That will prevent any feedback . >> Hello again. My name is Christopher Keck with family connections. I am your moderator. I am here with Shannon Staley in South Carolina that she is presenting Medicaid 101. Before we start, let's take a moment to make sure everyone is ready and familiar. First all participants will be muted during the presentation portion of the webinar. To communicate use the chat panel on the bottom right-hand corner of the screen. You can use the chat panel for issues like not being able to hear or questions about

 the content, you can type questions as you go. If the answer can be presented in the webinar, and answer will be responded to you. We will also have a Q&A session at the end of the webinar . The phones will be and muted at that time. Next we will also have real-time closed captioning available and if you have issues with the captioning let us know via the chat feature.

With the housekeeping out of the way let's get started. Again today's presenter is Shannon Staley. Far -- Coordinator for Family Connection SC for Medicaid and related services. She conducts all of the Medicaid items . [indiscernible] Shannon will present Medicaid 101. >>

 We are going to give you some hopefully new and useful information hopefully on Medicaid. A little on Social Security, a little on general insurance, hopefully like I said you will come away with some valuable information.

 So the objectives for today, we will review the Medicaid categories. The biggest one is partners for healthy children or PHC. The second category is TEFRA . We will bill -- drill deep on this. Keep in mind, look at the print. If you print this out it will be very definitive and succinct in terms of who qualifies under what circumstances. So if we get in the weeds about TEFRA during the presentation refer back , it will be posted on the website at some time afterwards. We will go through the process ineligibility. We will look at the difference in health plans. We will look at mileage reimbursement and the HIPP program. I believe I will give you some new beneficial information that you could share with your family. And information current at the top of the presentation if this hangs around for any while anywhere, these figures for the federal poverty level change every year. These are updated in March four 2018. This does not include all of the Medicaid categories. You can refer to DHHS for the entire list. When it comes to Medicaid we often refer to it as a room with two doors. One door is federal, that would be SSI. And that is one way to qualify or to be eligible for Medicaid , through SSI. The other door is through the state. That would be through DHHS . There are four main categories to look at for state eligibility. One is TEFRA , one is Ortner's for healthy children, one is aged , blind and disabled or ABD. And then family-planning and pregnant women, FP and PW . This is what you think of when you are dealing with pregnant women.

Myths about Medicaid. There are many and there could be 50 slides on this. These are the three we have chosen for today. If a child has a disability then they should apply for TEFRA . That would be untrue. It is tricky here with the word disability, but basically what it is saying is just because your child has a need or a deficit, or a challenge or diagnosis, it does not necessarily mean they will meet the criteria for getting TEFRA . That is a disability determination. There are many things that need to be in place in order to meet the criteria for disability for TEFRA . A family who has private insurance would not qualify for Medicaid. Untrue. Most of our families that are applying for, or receiving TEFRA , have private insurance most often through an employer. That is perfectly fine. The way that works is the private insurance pays as the primary payer. The first payer. And Medicaid comes in as a secondary payer behind that. Things like deductibles, coinsurance, copayments, any caps on coverage . Medicaid will come in and pay. And the third one, a child has to have Medicaid under TEFRA to qualify for other Medicaid services that are disability related . That is untrue.

So Medicaid eligibility. Partners for healthy children, PHC, this is what most people think of when they think of Medicaid. The criteria for that is the child must be under the age of 19, the income level needs to be at or below 208 percent of the federal little -- federal poverty level, FPL. An example of that is for a family of four , the monthly gross income needs to be no more than $4350.66. The gross means before anything is taken out. This would be for a family of four. That gives you a general idea of sort of how the income eligibility piece might work. All children in the household will be covered. That is the good thing about this eligibility category. It is not specific to one child, it covers all of the children. And they will receive the full benefit plan. >> Aged, blind and disabled, ABD, you need to be 65 or older, blind or totally and permanently disabled and the income needs to be at or below 135 percent of the federal poverty level. There's and examine -- an individual example, $1366 a month gross, or for a couple, the aggregate income can be no more than $1852 a month. That is gross. One thing to keep in mind about this category, there is a resource limit. The resources need to be at or below $7560 for an individual, or $11,340 for a couple . They will receive the full benefit plan.

Family-planning and pregnant women and infants. The eligibility criteria for that , are that the family income needs to be at or below 194 percent of the federal poverty level. An example of that is a family of four can make no more than $4057.83 a month. That is gross. The woman must be pregnant. She will receive the full benefit plan , as will the baby.

 The coverage for the woman will include 60 days postpartum. That is a good thing because it will pick up the first postpartum visit . It is a challenge because after that point she has to qualify under another eligibility category in order to have Medicaid. Very often she will not. >>

 After the 60 day postpartum periods, she can be moved to healthy connections checkup which is a limited benefit program. Coverage for the newborn last for one year. At the one-year mark, that newborn needs to be eligible under another category, whether it is partners for healthy children, SSI, TEFRA , any of those. At the one-year mark that's usually where the transition takes place.

So TEFRA, often referred to as the Katie Beckett waiver . It is not technically a waiver. It was established under section 134 of the tax equity and fiscal responsibility act of 1982, known as TEFRA . State were allowed to make Medicaid benefits available to certain disabled children who would not ordinarily be eligible for supplemental security income, SSI , benefits. Because of their parents income or resources. South Carolina began covering these children effective January 1 of 1995.

 It is a wonderful thing that our state has this. Not all states do. Some do not offer this coverage at all. So we are very fortunate that we have this help for our families.

For TEFRA , the eligibility criteria are, the child needs to be 18 or under. The child must live at home.

 The most common example of this being an issue as if the child is still in the NICU. The child needs to be at home at the time you apply for TEFRA . The child must meet the SSI definition of a disability. The child's income must be below $2250 a month. The parents income and resources are not counted. Very rarely do we have the child's income as an issue. The child's resources must be at or below $2000.

 This can be an issue. Most often when it is a checking account or savings account, that was established when the child was little or before they were born, where people contributed over time, it is a simple remedy to get rid of that. Either take the child's name off or get rid of the account so at the time you apply that resource is not there. The 529 plans or anything the child cannot actively access, and does not have a cash value, they do not count. So you are fine if you have those . if you have any questions, things that your child may be receiving in some other way , that might interfere with these criteria, a special needs trust is an option that might be helpful. You would need to speak to a special needs trust attorney to have that set up. >> Children must meet an institutional level of care that there are three. The first and most commonly applied is the intermediate care for intellectual disabilities, referred to as ICF-ID . The second slightly more intensive level is the nursing facility. Skilled or intermediate care. And the third most intensive level is hospital care.

Meeting an institutional level of care does not mean that the child must be institutionalized, it is simply a way of denoting the level of care, how much care, and what kind of care the child needs.

Eligibility.

 It must be appropriate for the child to receive care at home. Very rarely do we have this as an issue. We do occasionally have children that are very involved, very ill, maybe on a ventilator or a traumatic injury, or a child on hospice or something like that. When there's any question as to whether they can receive care at home. Very often it is not an issue. Estimated cost of care at home is less than the estimated cost of institutional care. That is usually a complete nonissue given the cost of things. And children eligible under TEFRA receive the full benefit plan. That is correct. The full benefit plan. >> I TEFRA determination can take at least 4 to 6 months . I would say in most cases six or more. The eligibility worker has to determine if the child meets the level of care and the federal guidelines for disability. These are two major components of the process that must be satisfied, in order to receive TEFRA . It takes time to receive all the medical records and reports from the listed providers. When I talk to parents I encourage them to get all of the records themselves. As opposed to the agency getting them. One reason being, it does speed up the process a little bit. The more important reason is if you are able to see what those records show, in other words if a lot of the records are very positive pointing, they talk about gains and progress, they don't focus as much on deficits , delayed milestones and things like that, that is a time when the parent, after looking at them, can say I probably need . And I advise them if this is the case, to go back to the provider and get a very honest assessment of where their child is as compared to a typical child without a disability. That would look at missed and delayed milestones, functional deficit, daily living, those kinds of things. The greater the need the more likely you are to be approved, the more therapy [indiscernible] prescribed or are being utilized. Those types of things will help you get approved, as opposed to being denied and having to appeal and waste two or four months doing that. I encourage my parents to get all of the records and take a look at them, copy everything they are sending so they have that copy for themselves, just in case. There have been some cases, very isolated, but some of that documentation has been lost. This way you have got it. You can go to your stack and give it to them and it is not frustrating and doesn't waste a lot of time.

A complete and accurate application is very helpful in the determination process. That is what I do, that's what I cohort of mine here does. We provide that service to families to make sure that the possibility of their application being denied is reduced because we have gone through the entire thing with our families to make sure it is done as accurately and correctly as possible and it is as complete as possible. >> TEFRA , the disability determination. After the medical records are received the application is sent to the South Carolina vocational rehabilitation department to determine disability. So the POC rehab takes over this portion of the process . A specialist is brought in to review the application if the disability is not clear. On occasion this can be true, there are gray areas with many things. Sometimes it is a matter of documentation, sometimes it's a matter of how that child is fitting into the process. >> And the next slide. It's not very legible and that is fine, it is really an example of how difficult it is to utilize any resources that are trying to tell you in advance if your child will meet criteria. The answer is, it is really very difficult. And it's pretty much impossible to tell. There are a few diagnoses that generally are approved. I try to stay away from that language. The fact of the matter is, when you do the 27 page application packet, when you gather all of those records , when the records are received by TEFRA , and the nurse has done the evaluation , when all of those things in the aggregate are assessed and compiled, that is the way the determination is made. There isn't really a way to do it in advance . Unfortunately there is no shortcut.

TEFRA level of care . To meet the level of care there must be functional deficiencies. They first look at the functional level of the child compared to other children of the same age. The first review determines whether the child would require ongoing care in a nursing home or hospital. Those of the two more involved levels of care we went over previously. Or if not,

 if the hospital or nursing level of care is not met , the application is sent to the South Carolina Department of disabilities and special needs, often referred to as DDSN , to determine if the child would need ongoing care and an intermediate care facility for intellectual disabilities. Often referred to as a ICF-ID . That is the category that 90 to 95 percent of our children fit under. The ICF-ID category .

What next ? After Medicaid is approved, Medicaid members will receive a Medicaid card and enrollment or outreach packet in the mail. Usually not at the same time. And do keep in mind, if you are dealing with families that are moving during this process, Medicaid does not forward mail. That is a reason that some folks have been frustrated in the process, because there was a missing link during the move. Just be aware of that.

Health plans . Medicaid health plan is the way a member gets health benefits . It is a group of doctors and other providers. All plans provide the same minimum Medicaid benefits. As an addition, health plans may also offer extra benefits like care coordination, asthma management and other disease specific programs or adult vision and dental . So a health plan within Medicaid is similar to an HMO in the private world. They refer to these as CMOS I'm sorry MCO's . In the managed-care world. A MCO is a company that contracts with primary care doctors, pharmacies, specialists, hospitals and other Medicaid service providers. You will hear this referred to as "in network close bracket.

The Medicaid member pics a PCP. Care is provided by the PCP or the PCP refers to appropriate providers in the network. So the PCP is sort of a gatekeeper for any other care you will get. Medicaid members enrolled in the MCO will receive the DHHS Medicaid card plus the MCO they are enrolled in. It is not clear to people they have been auto enrolled in a MCO. Or even what one is . If they happen to have two cards, that at least will tell you they are in fact in and MCO . Both cards should be presented to Medicaid service providers. It will avoid billing errors that can be frustrating.

Fee for service. Fee-for-service Medicaid is also referred to as regular or full Medicaid. There is no network, no gatekeeper. You can go to any provider that accepts Medicaid. Fee-for-service is not available to all Medicaid members.

This is the part where it gets a little complicated. This presentation, if you print it would be a good guide for you to better understand who qualifies for what. >> So required participation. Certain categories of Medicaid members are required to choose a managed-care organizational -- organization or MCO. Anyone with partners for healthy children must be in a MCO. Parent and caretaker relatives, PCR's previously known as low income families or LIF's, must be in and MCO. For disabled children, aged blind and disabled the budget a 19 -- abutted -- above age 19 or any SSI child age 19 and above must be in a MCO . The most important thing in this light is if a procedure or treatment is deemed both medically necessary, and that service cannot be obtained in South Carolina, you can get a physician to write this, turn it over to Medicaid, and if they approve and agree that those two things are in fact true, then your benefits, along with transportation, can apply to out-of-state care.

This is not a complete list, please refer to the DHHS for the entire list . >> Some categories have optional participation that they can do MCO or FFS coffee for service. That would technically be TEFRA or Katie Beckett folks that most people would opt for fee for service since it gives you more options. Disabled children receiving SSI could technically be in a MCO if you chose. And aged, blind and disabled, under age 19, could be in a MCO but all three of these categories can be fee for service. You can call Healthy Connections choices and switch from one to the other , that would be done for you without an issue . This is not a complete list, please refer to DHHS for the entire list .

So we do have categories that are not eligible to be in a MCO . Some categories are not eligible so remain fee for service. One example is any beneficiary that is receiving home and community-based waiver services. This does not mean when you are on the waiting list, or when you have been awarded a slot, it means when you are in fact technically receiving services. At that point in time, you are supposed to be fee for service. It is supposed to be done automatically, sometimes it is not . There can be a little confusion on that one. Folks receiving waiver services should be able to access fee for service. People receiving hospice. They not only have the issue that is causing them their demise, but they have all kinds of other issues coming up as a result of being in decline. They need access to as many care providers as they need. The Bestway to do that is to be fee for service. They are not supposed to be in a MCO .

A growing category, the dual eligible, Medicare and Medicaid folks, are not supposed to be in a MCO either. Again this is not a complete list.

 For mileage reimbursement. Hopefully I will be able to to tell you something you didn't know that will help families. Mileage reimbursement is for nonemergency transportation, and it is available through LogistiCare . LogistiCare has different contracts. It is for Medicaid recipients who need to see a doctor . Go to other medical appointments, or visit the drugstore . That's what I want to emphasize for you. All of the drugstore visits can have mileage reimbursement. And if there are more than one person in the house, that is receiving Medicaid, if the family is rural, if there are multiple prescriptions do at different times, that little bit can add up to a significant amount. So remember to tell your families, that trips to the drugstore are covered.

All Medicaid members are eligible for mileage reimbursement, so all the eligibility categories we went over are eligible for this. LogistiCare reimburses mileage from any point that Medicaid pays out. That is your guide. If Medicaid will pay out for the service, you likely can submit reimbursement for the mileage, and/or if you need the transportation, that can be obtained also through LogistiCare.

Mileage reimbursement can be throughout the state of South Carolina. It is , if out-of-state services are received, LogistiCare does not pay. That is technically correct. One is the exception I mentioned earlier, in some cases where if your positional state, that is your service, is medically necessary and not available in South Carolina, sometimes they will approve both coverage and expenses for out-of-state services. >> LogistiCare also has two ways to access their services. One is online which I have been told, if you like dealing with the Internet and entering data and things like that and you're comfortable with it, it is pretty intuitive and easy to use. You set up an account, you get a trip ticket number, and you take a piece of paper, where ever it is you are going so the person you are going to see can say you showed up. That is how the trips are logged. If you're not comfortable with that they have a full paper version. Where all of it is done , either way is fine. You would be surprised if your willing to put in more effort , how easy it can be to get that done.

I department that doesn't get a lot of attention that can be really helpful to some parents, is the health insurance premium payment program, referred to as HIPP. In this program , DHHS will pay health insurance premiums , for the existing private coverage, if they find it cost-effective.

 EOBs or explanation of benefits are used to determine cost-effectiveness. Those are the forms the insurance company sends to the beneficiaries , or to the insured, that outlines what was paid out by private or whatever. The service you received. Those are used to determine cost-effectiveness . it does not change Medicaid services or eligibility. The Medicaid member must be enrolled in fee-for-service Medicaid. That is something to pay attention to. They have to have, generally speaking, TEFRA or SSI, as a child. If they have partners for healthy children, this generally doesn't apply. Theoretically what this could do, say for instance the private health insurance plan, they will cover the policyholder, and the child. There premium . Let's assume that aggregate amount is $400. For the policyholder and the child monthly. If when you submit, you have to show your pay stubs to show you are in fact paying towards a private plan. And the explanation of benefits. When that is received by HIPP, they review their calculation. And let's say two or 34 times the $400 on a monthly basis to care for that child, it could be possible for that premium to be paid. So Medicaid does not end up being primary. They don't want to have a private plan, to cancel that plan and then pay for everything. They would much rather help the beneficiary keep their private, have the private plan paid first and then have Medicaid always be secondary to this is a very good program for children that are getting a lot of services and have a lot of needs. They could really help families. >> So we are at the question-and-answer phase. Chris will help me figure out .

There were a couple of questions in the chat pod that I would like to address first, before we open the phone lines for questions. >> This is the one from ?

From Becky Merrick.

Where can you find link for paper forms on the fees for reimbursement. You can go to the LogistiCare website , or if you want to Google LogistiCare and get their contact information. You can call them. It is divided up into regions but if you tell them what county you live in, they can direct you on how to set up either the online account or the paper-based account.

 And Eric Schultz ask a question when does TEFRA end for a child ? Age 18? >> It is the last day of the 18th year of life. That ends up being a good thing , because the parent that will have to make decision about transitioning from childhood to adulthood, it sort of means if there is an extra year, from 18, to the last day of the 18th year of life, giving parents a little time to figure out where they are and how they want to handle their children being adults and accessing benefits.

Another question, I have two kiddos who do not have a diagnosis, but do need TEFRA . Had we get them this insurance?

 It depends somewhat on the diagnosis and what paperwork you do have . I diagnosis is very helpful. It is not mandatory. Especially if the children are much younger but if they are very young and they don't yet have a diagnosis but they have been prescribed therapies, medications, medical devices, have had procedures and those kinds of things. Sometimes a diagnosis is not required. But you do need documentation that shows there is a need for services.

The next one says my child has down syndrome. Would he qualify for TEFRA ?

Down syndrome is one of the handful of diagnoses that generally is approved . So if you have documentation, ideally that shows the diagnosis, you don't have to have as much documentation as some of these other situations might require that generally, that diagnosis is approved.

How do families submit mileage reimbursement request? Is there a link or paper form?

For mileage reimbursement you need to set up accounts with LogistiCare . You can do it on the phone, by calling them, or go online and set up an online account. If you call that is most likely the paper version you are opting for. There will be a way for you to enter that data , if you choose the online version. You enter the data into the system. Or if you get the paper version, there are forms you can access on the website and print out.

The next one, since Medicaid now pays up to $750 annually for adult dental, with the Medicaid then be available for transportation?

 The Medicaid [indiscernible] and reimbursement applies to any service Medicaid would pay out for. If your service or product, is something Medicaid is going to reimburse for , then transportation should be available as well.

How far back can my client be reimbursed for mileage?

There is no retroactive reimbursement for mileage unfortunately. >>

 All right. We can open the phone lines. Let me unmute those . >> If you have a question, feel free to ask.

Let us know if you are not an muted -- released from you .

-- Mute. >> Go ahead with your questions if you have any, I am happy to help. >> I have a question about the mileage. Can you hear me? You said that it cannot be retroactive. How do you measure it then? You have to measure the mileage and then submit it.

I am sorry. What I meant by that , you need to have an account set up. You cannot get reimbursed for trips previously taken, if you don't have a trip ticket for it.

Okay. So you have to set it up in advance.

Yes. Set up the account first. They didn't always used to do this but now if you have repetitive trips, they often will let you get those trip tickets right then. You don't have to call before each and every trip separately. They will let you do some if they are repetitive.

Thank you.

You are welcome.

In the chat box, do you know how much the reimbursement is quick

Mileage reimbursement is based upon the federal reimbursement rate for mileage. It fluctuates. I don't happen to have that in front of me. You can look that up pretty easily on Google. Also when you call to set up your account, at that time , it doesn't change on a super frequent basis. At the time you call and set up your account, you can ask them what the current federal reimbursement rate is, i.e. what their rate of the reimbursement is. >> The Bess place to get the application for TEFRA actually is our website. That application changes. To help families get the quickest, most accurate results in applying, if they have the correct version, that is important. If you go to family connection, it is on our website. It is a PDF that you download. It should be 27 pages. Again we will go question my question with families to help them . It is confusing because it tells you to fill out certain things that for TEFRA you do not. We guide them through the process and tell them what they can skip , what is mandatory. We give them instructions on how to vest use that application, in a way that will have them be approved. >> Another question online. Shannon, we are under the impression that the ABD is 100 percent of the federal poverty rate ?

It says income at or below 100 percent of FPL. That is what I have . >> Many people have asked about downloading the slides. If you look into the center of the screen, under the files box, there is a PowerPoint you can click on and hit download file. >> If you do that, please stay with us a little while longer. >> Okay. If someone moves to South Carolina from another state who was refuting Medicaid funded services -- receiving Medicaid funded services , and need them here, what is the quickest or Best way to get Medicaid in place for these services to be received here? >> Unfortunately each state administers a program differently. Just because you have received services and another state does not mean you will receive them in the state you move to. You have to reapply with all of your documentation . It is also based on the last 15 months timeframe. It is okay that the doctors are from another state. But you have to reapply as a resident of the current state.

Once the TEFRA form is filled out and the 4 to 6 months

 to make determinations, will any other services be covered during the 4 to 6 months once approved?

There is a three month period on the 3400 Medicaid form , when you fill it out. There is a box that we make sure our families check that says would like help paying for unpaid medical bills for the previous three months. There is that time.. It sometimes can be longer. There are exceptions I don't want to delineate here. Generally it is three months. Keep in mind that the reimbursement goes back to unpaid providers , it does not go back to parents for having paid bills . One of the things that we try to inform parents on if we have the chance, and they are not totally overloaded by what we are saying, is to go to the providers and asked them if during that time., The determination., If they would consider not pursuing the parents for the unpaid portion. This is assuming

 there is private insurance and the private insurance doesn't pay everything. The unpaid portion is what Medicaid can go back and reimburse those providers for. As often as possible we try to outline to the parents they can approach the provider to do this but sometimes they agree and sometimes they won't. The downside of that is if they are not approved for whatever reason they will have to pay that. >> Any more questions? Yes.

Some typing going on. >>

 All right. Do we have some more questions? Somebody was typing and then maybe decided not to. >> What we are experiencing at the moment is a little of a change in the process. That was that it used to be when I nurse would come out to evaluate the child, that gave both the parents and TEFRA , and us as we got questions from parents , an idea of where they were in the process. That is not true anymore . What we are finding is that sometimes a nurse comes out very early on. It used to be it was a little closer to the end stage when the nurse would come out, and therefore you knew you were close. Now it can happen at any time. There is really not a way, if you want to call we tell our families you can certainly call TEFRA and asked for a status update. Very often the answer is it is pending . They don't give you an idea exactly where they are and all of the stages with the determination . So generally it is around six months that we are finding and sometimes longer. >> There is an echo apparently.

Thank you Lynn. >> Hopefully you guys were able to hear sufficiently, even with an echo. >> All right. If you have a burning desire to ask a question, please do it in the next couple of minutes. Otherwise we will wrap it up . Again this will be available on our website in the next day or so .

A couple of days.

Two days to four days. Please refer people directly to us. We are more than happy to again go item by item through their . There were many things I didn't have a chance to go over with you here. That we also, I think our parents that come through this process have an advantage over other applicants, in terms of the probability of approval, based on what is in the application in the medical records. So we are very anxious to help . There are two of us here that do it. We are more than happy. >> Super. So glad this was helpful. The help will keep on coming if you give us a call, if you have a question or a parent that needs something. Just let us know.

The number on the slide, the 800-578-8750 goes directly to the family information center. They can put you in touch with Shannon. >> Excellent, thank you everyone for your attendance. We appreciate it greatly.

 Thank you.

You are welcome, have a great day everyone. >> [Event concluded]