GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Missouri, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2024

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Missouri, USA

In-Kind Benefits

Plan details 1992-2024 * †

Public long-term care (LTC) benefits in Missouri are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Missouri, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria. Missouri is a 209(b) state, one of relatively few states that chooses to use more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program for its main eligibility track.

Since 1992, Missouri's Medicaid LTC system has been subject to two major policy reforms: in 2002, Missouri increased the standard income limit for Medicaid eligibility by 8.4% (to 80% of the federal poverty limit, FPL), and further increased this limit to 90% of the FPL in 2004 and to 100% of the FPL in 2005 before reducing it to 85% of the FPL from 2006. In 2021, Missouri implemented a new care needs assessment to determine eligibility for LTC services.

Key Dates

First law: 1965

Major changes since 1992: 2002, 2021

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2001

Overview

Long-term care (LTC) benefits in Missouri are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Missouri is administered at the state level by the Division of Medical Services (DMS) within the Department of Social Services, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. Missouri is one of 8 states that chooses to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program, making it what is known as a 209(b) state. LTC benefits in Missouri are mostly provided through state plan benefit programs (Home Health Services, Personal Care Services, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (Aged & Disabled).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by the Aged & Disabled program are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for the Aged & Disabled Program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list prioritized by need.

Benefit programs vary in dependence requirements. Home Health Services require the individual to have a medical necessity for services, while Personal Care, Nursing Facility, and Aged & Disabled program services require beneficiaries to meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Policy changes during this period:

- (1993) Missouri created a new eligibility track, which we refer to to as eligibility track 2a (Institutional rules for people receiving LTC), that has greater income limits for Aged & Disabled program beneficiaries in order to incentivize the use of HCBS over nursing facility care (MDSS, 1992b).
- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration (U.S. Congress, 1996).
- (1999) Effective January 1, the age limit for the Aged & Disabled program was lowered from age 65 to age 63 for individuals with a physical disability (MDSS, 1999).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Missouri Law for Medicaid

- Missouri Code of State Regulations Title 13: Rules of the Department of Social Services
  - Division 15: Division of Aging, Chapter 9: Certification (CSR, 1998b)
  - Division 70: Division of Medical Services, Chapter 10: Nursing Home Program (CSR, 1998d; CSR, 2023a)
  - Division 70: Division of Medical Services, Chapter 90: Home Health Program (CSR, 1993b; CSR, 2023b)
  - Division 70: Division of Medical Services, Chapter 91: Personal Care Program (CSR, 1998e; CSR, 2023c)
  - Division 40: Family Support Division, Chapter 2: Income Maintenance (CSR, 1998c; CSR, 2022a)
- Missouri Code of State Regulations Title 19: Rules of the Department of Health and Senior Services
  - Division 30: Division of Regulation and Licensure, Chapter 81: Certification (CSR, 2001; CSR, 2022b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Missouri Medicaid spending on beneficiaries in fiscal year 1992 was 60.84%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending, though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Missouri Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Missouri.

Eligibility for Medicaid in Missouri for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks. Eligibility for nursing facility care is achieved through eligibility track 1b, and eligibility for home and community-based services is achieved through eligibility track 2a:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States
  Individuals requiring Medicaid eligibility to access nursing facility care services must qualify for Medicaid through this eligibility track. Missouri is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - ◇ Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, this was $422 for an individual and $633 for a couple. See Table 2 for historical monthly benefit amounts. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[2] Individuals who do not meet this income threshold are able to "spend down" their excess income either by incurring medical expenses that decrease income down below the threshold, or by making monthly payments in the amount of their excess income to the state (CSR, 1998c).
  - ◇ Asset requirements: Resources may not exceed $999.99 for an individual and $2,000 for a couple. See Table 3 for annual asset limits. Additional asset disregards exist if a person is enrolled in the Aged & Disabled program and has a spouse residing in the community.[3]
    - ▪ Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[4]
  - ◇ Citizenship/immigration requirements: The applicant must be a Missouri resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[5] From 1996, the applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted uner Section 207 of the Immigration and Nationality

Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024a) for additional information.

- ◇ Other requirements
  - The applicant must be at least age 65, blind, or disabled.[6]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC—From 1993
  Eligibility for Medicaid through this track is limited to individuals accessing HCBS through the Aged and Disabled program (MDSS, 1992b; CMS, 2024b). Individuals requiring Medicaid eligibility to access nursing facility care cannot use this eligibility track to qualify.
  - ◇ Income requirements: Monthly income may not exceed $750 (MDSS, 1992b). From 2001 this figure increases annually with inflation. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical monthly benefit amounts. Additional income disregards exist if a person is enrolled in the Aged & Disabled program and has a spouse residing in the community.[2]
  - ◇ Asset requirements: Resources may not exceed $999.99 (MDSS, 1992). Assets for this track are evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is enrolled in the Aged & Disabled program and has a spouse residing in the community.[3]
    - Asset transfer: Same as eligibility track 1b.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - ◇ Other requirements
    - From 1999 the age limit for the Aged & Disabled program was lowered from 65 to include individuals aged 63-64 with a physical disability (MDSS, 1999).
    - The applicant must be receiving or in need of LTC services through the Aged & Disabled program.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast or Cervical Cancer Treatment (BCCT): Provides Medicaid coverage, including long-term care, for women who are under age 65 with income up to 200% of the FPL who have been found to have breast or cervical cancer including a precancerous condition. Missouri implemented its Breast and Cervical Cancer Control Project effective August 28, 2001 (MDSS, 2001).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Personal Care Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Aged & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65. From 1999, individuals could also be eligible if they were aged 63-64 with a disability (MDSS, 1999). While the state intends to have enough program slots to accommodate all eligible beneficiaries, if the program reaches enrollment capacity applicants are placed on a waiting list based on need until a spot becomes available (MDSS, 2013).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- AIDS program
- Program of All-Inclusive Care for the Elderly (PACE)—from 2001

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

Home Health provides (CSR, 1993; CSR, 2023b):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are capped at 3 hours per day and 100 visits per calendar year. Until 2020 home health aide services were required to be provided concurrently with skilled nursing services (CSR, 1993b; CSR, 2020b).

Personal Care Services

Personal care services (PCS) provides (CSR, 1998e; CSR, 2023c):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Missouri provides basic and advanced PCS. Basic PCS assist with ADL and IADL support when the beneficiary does not require devices and procedures related to altered body functions. Advanced PCS are provided to beneficiaries who require devices and procedures related to altered body functions. Total monthly PCS are subject to a cost limit of 60% of the average monthly cost of care in a nursing facility.

Nursing Facility Care

This program does not provide home care.

Aged & Disabled

The Aged & Disabled program provides (MDSS, 1992b; MDSS, 2021b; CMS, 2023a):

- Homemaker services: Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

Community care

Community care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services, Personal Care Services, Nursing Facility Care

These programs do not provide community care.

Aged & Disabled

The Aged & Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (MDSS, 1995; MDSS, 2013; MDSS, 2021b; MDSS, 2023a). While ADHC was not offered as a service when the Aged & Disabled program was implemented in 1993, it was offered from 1995. Authors have not yet determined whether the service was offered in 1994.

Residential care

Residential care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services, Personal Care Services, Aged & Disabled

These programs do not provide residential care.

Nursing Facility Care

Missouri Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs (CSR, 1998d; CSR, 2023a). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing

- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Missouri's largest home and community-based services (HCBS) program.

Missouri Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Aged & Disabled

The Aged & Disabled program provides services in addition to those offered under the state plan, unless otherwise noted (MDSS, 1992b; HHS, 1992):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Division of Aging (DA) within the Department of Social Services (DSS) until 2001 when it was moved under the Department of Health and Senior Services (DHSS) and renamed the Division of Senior Services. In 2018, the Division of Senior Services was renamed the Division of Senior and Disability Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provided services through home health agencies certified by the DSS until 2001, and by the DHSS from 2002 (CSR, 1993b; CSR, 1998a; CSR, 2021; CSR, 2023b).

Personal Care Services

Personal care services are provided by personal care aides under the supervision of a registered nurse employed by DSS or DHSS-certified provider agencies (CSR, 1998e; CSR, 2023c).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of DSS or DHSS-certified nursing facilities (42 CFR 483.30).

Aged & Disabled

Aged & Disabled program services are provided by DSS or DHSS-certified service providers, with respite, homemaker, and chore services provided by trained service staff under the supervision of registered nurses (CSR, 2002a; MDSS, 2023a).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. The beneficiary must be homebound, defined as having a medical condition that restricts their ability to leave the house except with the aid of assistive devices, and there must be no other caregiver available to provide the services needed (CSR, 1993). The homebound requirement was eliminated in 2010, and replaced with the requirement that services be necessary to maintain the beneficiary at home (CMS, 2010; CSR, 2023b).

Personal Care Services

The beneficiary must require a nursing facility level of care (NFLOC), and services must be medically necessary as an alternative to institutional care. An NFLOC is met if the individual receives at least 18 points on the state level of care assessment (CSR, 1998b; CSR, 1998e; CSR, 2023c).

Nursing Facility Care

The beneficiary must meet an NFLOC by satisfying the same LOC determination and point threshold described under Personal Care Services, and by exhibiting both physical and mental impairment such that they require skilled nursing care (CSR, 2001; CSR, 2022b).

Aged & Disabled

The beneficiary must meet an NFLOC by satisfying the same LOC determination and point threshold described under Personal Care Services, and by having their need for at least one program service per month prior authorized (MDSS, 1992b; MDSS, 2021b).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (CSR, 1993b; CSR, 2023b; 42 CFR 484.55).

Personal Care Services

NFLOC is recertified through an in-home assessment as needed, in order to redetermine the beneficiary's need for services or adjust the type or amount of services needed (CSR, 1998e; CSR, 2023c).

Nursing Facility Care

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (CSR, 2001; CSR, 2022b).

After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (42 CFR 483.128), and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20).

Aged & Disabled

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (MDSS, 2013; MDSS, 2021b).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care, Personal Care Services

There is no age requirement.

Aged & Disabled

The individual must be at least age 65. From in 1999, individuals may also be eligible if they are aged 63-64 with a physical disability (MDSS, 1999).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

Home health is covered for beneficiaries who are homebound, and who require skilled nursing services or physical, occupational, or speech therapies as ordered by a physician in a plan of care. The homebound requirement, in effect through 2010, is met if the beneficiary has a condition due to an injury or illness which restricts their ability to leave their place of residence except with the aid of supportive devices, special transportation, or the assistance of another person. The beneficiary may qualify as homebound even if they occasionally leave the home for nonmedical purposes, as long as the absences are infrequent, short in duration, and do not indicate that the beneficiary has the capacity to obtain the needed care on an outpatient basis (CSR, 1993; CMS, 2010).

Personal Care Services

The beneficiary must require a nursing facility level of care (NFLOC) by scoring at least 18 points on a screening tool that assesses the beneficiary's cognitive and functional impairment as well as care needs across 9 level of care (LOC) categories (CSR, 1998b; MDHSS, 2021a). In 2005 the point threshold required to qualify as requiring an NFLOC was increased to 21, and in 2017 it was increased again to 24 (CSR, 1998b; CSR, 2005a; CSR, 2018). See Box 2 for assessment and scoring details for the following LOC categories: monitoring, medications, treatments, restorative services, and rehabilitative services. See Box 3 for LOC categories: personal care, dietary, mobility, and behavioral and mental condition.

In addition to requiring an NFLOC, in order to qualify for personal care services (PCS) a beneficiary must also be capable of living independently with PCS (CSR, 1998e).

Nursing Facility Care

To qualify for care in a skilled nursing facility the beneficiary must meet an NFLOC and exhibit both physical and mental impairment such that skilled nursing services are required to address their care needs (CSR, 2001). NFLOC is determined using the same criteria described above under PCS.

Aged & Disabled

To qualify for Aged & Disabled program services, beneficiaries meet an NFLOC and must have their need for at least one program service authorized in advance of receiving program benefits (MDSS, 1995). NFLOC is determined using the same criteria described above under PCS.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner must order home health services in accordance with a plan of care that establishes medical need based on an in-person assessment. The plan of care is certified using form HCFA-485: Home Health Certification and Plan of Care, known after 2001 as form CMS-485, which collects information including functional limitations and cognitive status (CSR, 1993b; CSR, 2002b; MDSS, 2023b). See Box 1 for the information collected on the HCFA-485 form, and see HCFA (1994) to view the full assessment form.

Personal Care Services

The beneficiary is evaluated during an in-home visit by Division of Aging (DA) staff in which the beneficiary's physical, social, and functional ability is assessed (CSR, 1998e). Care needs are evaluated using a level of care (LOC) determination tool that assesses care needs across 9 LOC categories. An individual must score 18 points or higher in order to meet a nursing facility level of care (NFLOC). See Box 2 for assessment and scoring details for the following LOC categories: monitoring, medications, treatments, restorative services, and rehabilitative services. See Box 3 for LOC categories: personal care, dietary, mobility, and behavioral and mental condition.

Effective July 1, 2005 the point threshold required to satisfy NFLOC was raised to 21 points, and effective July 17, 2017, the point threshold was raised again to 24 points (CSR, 2005a; CSR, 2018).

Nursing Facility Care

The beneficiary is referred to the DA for screening and assessment by a nursing facility or service provider, after which DA staff have 5 days to contact the beneficiary to conduct the screening and inform the beneficiary of their institutional and home-based options. The pre-admission screening is conducted using Initial Assessment - Social and Medical Form DA-124A/B, which is also used to evaluate and certify the potential beneficiary's level of care needs. NFLOC criteria are the same as described under Personal Care Services. See Box 4 for the information collected on the DA-124A/B form, and see MDSS (1998) to view the full assessment form.

If the individual chooses to enter a nursing facility, they are given a DA-13 form with documentation of their screening results to be filed with the nursing facility. A full resident assessment using the Minimum Data Set (MDS) is conducted within 14 days of admission to the facility (MDSS, 1994; CSR, 2001).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the MDS. See Box 5 for more information on the PASRR, and Box 6 for the MDS.

Aged & Disabled

Potential beneficiaries are referred for home and community-based services (HCBS) by first contacting the Central Registry Unit, which serves as the DA's statewide unit for processing referrals and which conducts a preliminary screening to determine whether the beneficiary should be referred to the DA for further screening and program entry using form DA-1. DA field staff then conduct an in-person care needs assessment using the same criteria described under Personal Care Services.[7] The results of the evaluation are submitted using HCBS referral form IM-54A, which is used to coordinate program eligibility and service provision between the Department of Social Services and the Department of Health and Senior Services (MDSS, 1995; MDSS, 2013).

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (CSR, 1993b).

Personal Care Services

The Division of Aging (DA) is responsible for assessing, approving, and case managing beneficiaries for personal care services based on an in-home level of care assessment. For advanced personal care services, the plan of care must be developed by the service provider's registered nurse in collaboration with the DA (CSR, 1998e).

Nursing Facility Care

Level of care evaluations are conducted by the beneficiary's attending physician, and are reviewed and assessed by DA staff or designated agents (CSR, 2001).

Aged & Disabled

The Central Registry Unit receives referrals for program services, and refers those deemed potentially eligible to DA social workers or nursing facility inspection staff for further screening and level of care evaluation (MDSS, 1995).

Benefit limitations

Can you mix LTC benefits?

All Missouri Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the four largest programs.

Medicaid

As required by federal law, Missouri enforces Estate Recovery. The acceptance of Medicaid in Missouri creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (RSMo 473.398; 42 USC 1396p(b)(1)).

Home Health Services

Available Missouri state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 1992, the PNA was $30 per month (CSR, 1998c).

Aged & Disabled

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2002-2020

Policy change in 2002
In 2002, Missouri increased the standard income limit for Medicaid eligibility by 8.4%, from $545 (the Supplemental Security Income benefit income limit) to $591 (80% of the federal poverty limit , FPL). This income limit was further increased to 90% of the FPL in 2004 and to 100% of the FPL in 2005 before being reduced to 85% of the FPL from 2006. The asset limit for Medicaid eligibility was not changed.
In 2002, Missouri increased the income limit for their main eligibility track (eligibility track 1b. 209(b) States) from the Supplemental Security Income benefit amount to 80% of the federal poverty limit (FPL).

Other policy changes during this period:

- (2002) Effective October 1, Missouri's spend-down rules allow individuals to qualify for Medicaid by paying their excess income directly to the Division of Medicaid, rather than having to incur medical and other qualifying expenses to bring their income below the eligibility limit (MDSS, 1992a).
- (2003) Effective October 1, the income limit for Missouri's main eligibility track (eligibility track 1b. 209(b) States) was raised to 90% of the FPL (MDSS, 2004).
- (2004) Effective July 1, the income limit for eligibility track 1b was raised once more to 100% of the FPL (MDSS, 2004).
- (2004) The Respite benefit provided by the Aged & Disabled program was split into Basic Respite and Advanced Respite benefits, corresponding to the level of skilled needs required by the beneficiary (MOA, 2004).
- (2005) The income limit for eligibility track 1b was lowered to 85% of the FPL (CSR, 2005b).
- (2005) Effective July 1, the point threshold required to satisfy nursing facility level of care (NFLOC) eligibility criteria was raised to 21 points (CSR, 2005a).
- (2006) Missouri implemented a home equity limit that made individuals with home equity above $500,000 ineligible for LTC. From 2011 this standard increases annually with inflation (MDSS, 2006).
- (2012) Beginning on January 1, the personal needs allowance (PNA) increased from $30 to $35 per month. The PNA was subject to annual increases of $5 until it reached $50 per month in 2015 (MDSS, 2011).
- (2017) Effective July 17, the point threshold required to meet an NFLOC was raised again to 24 points (CSR, 2018).
- (2017) The asset limit for eligibility track 1b. 209(b) States increased to $2,000 for an individual and $4,000 for a couple. These standards increase annually with inflation (CMS, 2017).
- (2020) Starting in 2020, home health aide services are no longer required to be provided concurrently with skilled nursing services (CSR, 2020b).

Overview

Long-term care (LTC) benefits in Missouri are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Missouri is administered at the state level by the Division of Medical Services (DMS) within the Department of Social Services, and enrollment is voluntary. In 2008 the Division of Medical Services was renamed the MO HealthNet Division.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. Missouri is one of 8 states that chooses to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program, making it what is known as a 209(b) state. LTC benefits in Missouri are mostly provided through state plan benefit programs (Home Health Services, Personal Care Services, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (Aged & Disabled).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by the Aged & Disabled are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for the Aged & Disabled Program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list prioritized by need.

Benefit programs vary in dependence requirements. Home Health Services require the individual to have a medical necessity for services, while Personal Care, Nursing Facility, and Aged & Disabled Program services require beneficiaries to meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Missouri Law for Medicaid

- Missouri Code of State Regulations Title 13: Rules of the Department of Social Services
  - Division 15: Division of Aging, Chapter 9: Certification (CSR, 1998b)
  - Division 70: Division of Medical Services, Chapter 10: Nursing Home Program (CSR, 1998d; CSR, 2023a)
  - Division 70: Division of Medical Services, Chapter 90: Home Health Program (CSR, 1993b; CSR, 2023b)
  - Division 70: Division of Medical Services, Chapter 91: Personal Care Program (CSR, 1998e; CSR, 2023c)
  - Division 40: Family Support Division, Chapter 2: Income Maintenance (CSR, 1998c; CSR, 2022a)
- Missouri Code of State Regulations Title 19: Rules of the Department of Health and Senior Services
  - Division 30: Division of Regulation and Licensure, Chapter 81: Certification (CSR, 2001; CSR, 2022b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Missouri Medicaid spending on beneficiaries in fiscal year 2002 was 61.06%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending, though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Missouri Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Missouri.

Eligibility for Medicaid in Missouri for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks. Eligibility for nursing facility care is achieved through eligibility track 1b, and eligibility for home and community-based services is achieved through eligibility track 2a:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States
  Individuals requiring Medicaid eligibility to access nursing facility care services must qualify for Medicaid through this eligibility track. Missouri is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.

- Income requirements: Monthly income may not exceed 80% of the federal poverty level (FPL).[1] In 2002, this was $591 for an individual and $796 for a couple. In 2003 the income limit was raised to 90% of the FPL, in 2004 to 100% of the FPL, and since 2005 has been set at 85% of the FPL. See Table 2 for historical monthly benefit amounts. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[8] Individuals who do not meet this income threshold are able to "spend down" their excess income either by incurring medical expenses that decrease income down below the threshold, or by making monthly payments in the amount of their excess income to the state (CSR, 1998c).
- Asset requirements: Resources may not exceed $999.99 for an individual and $2,000 for a couple. In 2017 the asset limit increased to $2,000 for an individual and $4,000 for a couple, and has been subject to annual increases since (CMS, 2017). See Table 3 for annual asset limits. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[9]
  - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[10]
  - Home equity limit: From 2006 the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (MDSS, 2006). From 2011 this figure increases annually with inflation (MDSS, 2010).[11]
- Citizenship/immigration requirements: The applicant must be a Missouri resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024a) for additional information.
- Other requirements
  - The applicant must be at least age 65, blind, or disabled.[6]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  Eligibility for Medicaid through this track is limited to individuals accessing HCBS through the Aged and Disabled program (CSR, 2005b; CMS, 2024b). Individuals requiring Medicaid eligibility to access nursing facility care cannot use this eligibility track to qualify.
  - Income requirements: Monthly income may not exceed $952 (MDSS, 2024b). This figure increases annually with inflation. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical monthly benefit amounts. Additional income disregards exist if a person is enrolled in the Aged & Disabled program and has a spouse residing in the community.[8]
  - Asset requirements: Resources may not exceed $999.99 (MDSS, 1992b). Assets for this track are evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is enrolled in the Aged & Disabled program and has a spouse residing in the community.[9]
    - Asset transfer & Home equity limit: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    - The applicant must be at least age 65, or age 63-64 with a physical disability.
    - The applicant must be receiving or in need of LTC services through the Aged & Disabled program.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast or Cervical Cancer Treatment (BCCT): Provides Medicaid coverage, including long-term care, for women who are under age 65 with income up to 200% of the FPL who have been found to have breast or cervical cancer including a precancerous condition.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Personal Care Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Aged & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 or between age 63-64 with a disability. While the state intends to have enough program slots to accommodate all eligible beneficiaries, if the program reaches enrollment capacity applicants are placed on a waiting list based on need until a spot becomes available (MDSS, 2013).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- AIDS program
- Program of All-Inclusive Care for the Elderly (PACE)
- Assisted Living program—from 2008-2012
- Adult Day Care program—from 2012
- Brain Injury program—from 2019
- Structured Family Caregiving (SFC)—from 2020

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

Home Health provides (CSR, 1993; CSR, 2023b):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are capped at 3 hours per day and 100 visits per calendar year. Until 2020 home health aide services were required to be provided concurrently with skilled nursing services (CSR, 1993b; CSR, 2020b).

Personal Care Services

Personal care services (PCS) provides (CSR, 1998e; CSR, 2023c):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Missouri provides basic and advanced PCS. Basic PCS assist with ADL and IADL support when the beneficiary does not require devices and procedures related to altered body functions. Advanced PCS are provided to beneficiaries who require devices and procedures related to altered body functions. Total monthly PCS are subject to a cost limit of 60% of the average monthly cost of care in a nursing facility.

Nursing Facility Care

This program does not provide home care.

Aged & Disabled

The Aged & Disabled program provides (MDSS, 1992b; MDSS, 2021b; CMS, 2023a):

- Homemaker services: Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

Community care

Community care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services, Personal Care Services, Nursing Facility Care

These programs do not provide community care.

Aged & Disabled

The Aged & Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (MDSS, 1995; MDSS, 2013; MDSS, 2021b; MDSS, 2023a).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services, Personal Care Services, Aged & Disabled

These programs do not provide residential care.

Nursing Facility Care

Missouri Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs (CSR, 1998d; CSR, 2023a). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Missouri's largest home and community-based services (HCBS) program.

Missouri Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Aged & Disabled

The Aged & Disabled program provides services in addition to those offered under the state plan, unless otherwise noted (MDSS, 2013; MDSS, 2021b; CMS, 2023a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
    - ◇ Basic respite: Maintenance and supervisory services provided to beneficiaries with nonskilled needs
    - ◇ Advanced respite: Provided to beneficiaries who are bedridden, have behavioral disorders, or have health problems who require monitoring and assistance

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Division of Aging (DA) within the Department of Social Services (DSS) until 2001 when it was moved under the Department of Health and Senior Services (DHSS) and renamed the Division of Senior Services. In 2018, the Division of Senior Services was renamed the Division of Senior and Disability Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provided services through home health agencies certified by the DSS until 2001, and by the DHSS from 2002 (CSR, 1993b; CSR, 1998a; CSR, 2021; CSR, 2023b).

Personal Care Services

Personal care services are provided by personal care aides under the supervision of a registered nurse employed by DSS or DHSS-certified provider agencies (CSR, 1998e; CSR, 2023c).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of DSS or DHSS-certified nursing facilities (42 CFR 483.30).

Aged & Disabled

Aged & Disabled program services are provided by DSS or DHSS-certified service providers, with respite, homemaker, and chore services provided by trained service staff under the supervision of registered nurses (CSR, 2002a; MDSS, 2023a).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. The beneficiary must be homebound, defined as having a medical condition that restricts their ability to leave the house except with the aid of assistive devices, and there must be no other caregiver available to provide the services needed (CSR, 1993). The homebound requirement was eliminated in 2010, and replaced with the requirement that services be necessary to maintain the beneficiary at home (CMS, 2010; CSR, 2023b).

Personal Care Services

The beneficiary must require a nursing facility level of care (NFLOC), and services must be medically necessary as an alternative to institutional care. An NFLOC is met if the individual receives at least 18 points on the state level of care assessment (CSR, 1998b; CSR, 1998e; CSR, 2023c).

Nursing Facility Care

The beneficiary must meet an NFLOC by satisfying the same LOC determination and point threshold described under Personal Care Services, and by exhibiting both physical and mental impairment such that they require skilled nursing care (CSR, 2001; CSR, 2022b).

Aged & Disabled

The beneficiary must meet an NFLOC by satisfying the same LOC determination and point threshold described under Personal Care Services, and by having their need for at least one program service per month prior authorized (MDSS, 1992b; MDSS, 2021b).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (CSR, 1993b; CSR, 2023b; 42 CFR 484.55).

Personal Care Services

NFLOC is recertified through an in-home assessment as needed, in order to redetermine the beneficiary's need for services or adjust the type or amount of services needed (CSR, 1998e; CSR, 2023c).

Nursing Facility Care

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (CSR, 2001; CSR, 2022b).

After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (42 CFR 483.128), and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20).

Aged & Disabled

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (MDSS, 2013; MDSS, 2021b).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care, Personal Care Services

There is no age requirement.

Aged & Disabled

The individual must be at least age 65, or age 63-64 with a physical disability (MDSS, 2013; MDSS, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

Home health is covered for beneficiaries who are homebound, and who require skilled nursing services or physical, occupational, or speech therapies as ordered by a physician in a plan of care. The homebound requirement, in effect through 2010, is met if the beneficiary has a condition due to an injury or illness which restricts their ability to leave their place of residence except with the aid of supportive devices, special transportation, or the assistance of another person. The beneficiary may qualify as homebound even if they occasionally leave the home for nonmedical purposes, as long as the absences are infrequent, short in duration, and do not indicate that the beneficiary has the capacity to obtain the needed care on an outpatient basis (CSR, 1993; CMS, 2010).

Personal Care Services

The beneficiary must require a nursing facility level of care (NFLOC) by scoring at least 18 points on a screening tool that assesses the beneficiary's cognitive and functional impairment as well as care needs across 9 level of care (LOC) categories (CSR, 1998b; MDHSS, 2021a). In 2005 the point threshold required to qualify as requiring an NFLOC was increased to 21, and in 2017 it was increased again to 24 (CSR, 1998b; CSR, 2005a; CSR, 2018). See Box 2 for assessment and scoring details for the following LOC categories: monitoring, medications, treatments, restorative services, and rehabilitative services. See Box 3 for LOC categories: personal care, dietary, mobility, and behavioral and mental condition.

In addition to requiring an NFLOC, in order to qualify for personal care services (PCS) a beneficiary must also be capable of living independently with PCS (CSR, 1998e).

Nursing Facility Care

To qualify for care in a skilled nursing facility the beneficiary must meet an NFLOC and exhibit both physical and mental impairment such that skilled nursing services are required to address their care needs (CSR, 2001). NFLOC is determined using the same criteria described above under PCS.

Aged & Disabled

To qualify for Aged & Disabled program services, beneficiaries meet an NFLOC and must have their need for at least one program service authorized in advance of receiving program benefits (MDSS, 1995). NFLOC is determined using the same criteria described above under PCS.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner must order home health services in accordance with a plan of care that establishes medical need based on an in-person assessment. The plan of care is certified using form HCFA-485: Home Health Certification and Plan of Care, known after 2001 as form CMS-485, which collects information including functional limitations and cognitive status (CSR, 1993b; CSR, 2002b; MDSS, 2023b). See Box 1 for the information collected on the HCFA-485 form, and see HCFA (1994) to view the full assessment form.

Personal Care Services

The beneficiary is evaluated during an in-home visit by Division of Aging (DA) staff in which the beneficiary's physical, social, and functional ability is assessed (CSR, 1998e). Care needs are evaluated using a level of care (LOC) determination tool that assesses care needs across 9 LOC categories. An individual must score 18 points or higher in order to meet a nursing facility level of care (NFLOC). See Box 2 for assessment and scoring details for the following LOC categories: monitoring, medications, treatments, restorative services, and rehabilitative services. See Box 3 for LOC categories: personal care, dietary, mobility, and behavioral and mental condition.

Effective July 1, 2005 the point threshold required to satisfy NFLOC was raised to 21 points, and effective July 17, 2017, the point threshold was raised again to 24 points (CSR, 2005a; CSR, 2018).

Nursing Facility Care

The beneficiary is referred to the DA for screening and assessment by a nursing facility or service provider, after which DA staff have 5 days to contact the beneficiary to conduct the screening and inform the beneficiary of their institutional and home-based options. The pre-admission screening is conducted using Initial Assessment - Social and Medical Form DA-124A/B, which is also used to evaluate and certify the potential beneficiary's level of care needs. NFLOC criteria are the same as described under Personal Care Services. See Box 4 for the information collected on the DA-124A/B form, and see MDSS (1998) to view the full assessment form.

If the individual chooses to enter a nursing facility, they are given a DA-13 form with documentation of their screening results to be filed with the nursing facility. A full resident assessment using the Minimum Data Set (MDS) is conducted within 14 days of admission to the facility (MDSS, 1994; CSR, 2001).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the MDS. See Box 5 for more information on the PASRR, and Box 6 for the MDS.

Aged & Disabled

Potential beneficiaries are referred for home and community-based services (HCBS) by first contacting the Central Registry Unit, which serves as the DA's statewide unit for processing referrals and which conducts a preliminary screening to determine whether the beneficiary should be referred to the DA for further screening and program entry using form DA-1. DA field staff then conduct an in-person care needs assessment using the same criteria described under Personal Care Services.[7] The results of the evaluation are submitted using HCBS referral form IM-54A, which is used to coordinate program eligibility and service provision between the Department of Social Services and the Department of Health and Senior Services (MDSS, 1995; MDSS, 2013).

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop the plan of care, and periodically review the plan of care (CSR, 1993b).

Personal Care Services

The Division of Aging (DA) is responsible for assessing, approving, and case managing beneficiaries for personal care services based on an in-home level of care assessment. For advanced personal care services, the plan of care must be developed by the service provider's registered nurse in collaboration with the DA (CSR, 1998e).

Nursing Facility Care

Level of care evaluations are conducted by the beneficiary's attending physician, and are reviewed and assessed by DA staff or designated agents (CSR, 2001).

Aged & Disabled

The Central Registry Unit receives referrals for program services, and refers those deemed potentially eligible to DA social workers or nursing facility inspection staff for further screening and level of care evaluation (MDSS, 1995).

Benefit limitations

Can you mix LTC benefits?

All Missouri Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the four largest programs.

Medicaid

As required by federal law, Missouri enforces Estate Recovery. The acceptance of Medicaid in Missouri creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (RSMo 473.398; 42 USC 1396p(b)(1)).

Home Health Services

Available Missouri state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2002, the PNA was $30 per month. Between 2012-2015 the PNA increased by $5 each year until it reached $50 per month (MDSS, 2011).

Aged & Disabled

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2021-2024

Policy change in 2021
In 2021 Missouri implemented a new nursing facility level of care (NFLOC) assessment to more closely align eligibility standards with service needs. Both the old and new standards were permitted during a three-year transition period as the new criteria were phased in. By April 2024, only the new standards were permitted for use.

Other policy changes during this period:

- (2021) Effective October 1, Missouri implemented Medicaid expansion under the Affordable Care Act (ACA), referred to here as eligibility track 2c (ACA expansion adults). This expanded Medicaid coverage to adults age 19-64 with income at or below 138% of the federal poverty level (FPL).
- (2023) The Division of Senior and Disability Services (DSDS) eliminated the prescreening step in its intake process for home and community-based service beneficiaries. Potential beneficiaries are now contacted directly by the DSDS to schedule their in-person level of care assessments (MDSS, 2021b).

Overview

Long-term care (LTC) benefits in Missouri are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Missouri is administered at the state level by the MO HealthNet Division within the Department of Social Services, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. Missouri is one of 8 states that chooses to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program, making it what is known as a 209(b) state. LTC benefits in Missouri are mostly provided through state plan benefit programs (Home Health Services, Personal Care Services, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (Aged & Disabled).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. People covered by the Aged & Disabled are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for the Aged & Disabled Program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list prioritized by need.

Benefit programs vary in dependence requirements. Home Health Services require the individual to have a medical necessity for services, while Personal Care, Nursing Facility, and Aged & Disabled Program services require beneficiaries to meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Missouri Law for Medicaid

- Missouri Code of State Regulations Title 13: Rules of the Department of Social Services
  - Division 15: Division of Aging, Chapter 9: Certification (CSR, 1998b)
  - Division 70: Division of Medical Services, Chapter 10: Nursing Home Program (CSR, 1998d; CSR, 2023a)
  - Division 70: Division of Medical Services, Chapter 90: Home Health Program (CSR, 1993b; CSR, 2023b)
  - Division 70: Division of Medical Services, Chapter 91: Personal Care Program (CSR, 1998e; CSR, 2023c)
  - Division 40: Family Support Division, Chapter 2: Income Maintenance (CSR, 1998c; CSR, 2022a)
- Missouri Code of State Regulations Title 19: Rules of the Department of Health and Senior Services
  - Division 30: Division of Regulation and Licensure, Chapter 81: Certification (CSR, 2001; CSR, 2022b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Missouri Medicaid spending on beneficiaries in fiscal year 2021 was 71.16%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending, though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Missouri Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Missouri.

Eligibility for Medicaid in Missouri for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks. Eligibility for nursing facility care is achieved through eligibility track 1b, and eligibility for home and community-based services is achieved through eligibility track 2a:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States
  Individuals requiring Medicaid eligibility to access nursing facility care services must qualify for Medicaid through this eligibility track. Missouri is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - ◇ Income requirements: Monthly income may not exceed 85% of the federal poverty limit (FPL).[1] In 2021, this was $912 for an individual and $1,234 for a couple (MDSS, 2021c). See Table 2 for historical monthly benefit amounts. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[12] Individuals who do not meet this income threshold are able to "spend down" their excess income either by incurring medical expenses that decrease income down below the threshold, or by making monthly payments in the amount of their excess income to the state (CSR, 2022a).
  - ◇ Asset requirements: Resources may not exceed $5,035 for an individual and $10,070 for a couple (MDSS, 2021a). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[13]
    - ▪ Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[14]
    - ▪ Home equity limit: The equity interest in the individual's home may not exceed $603,000, or else they will be ineligible for LTC services (MDSS, 2020). This figure increases annually with inflation.[11]
  - ◇ Citizenship/immigration requirements: The applicant must be a Missouri resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration

and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024a) for additional information.

- ◇ Other requirements
  - The applicant must be at least age 65, blind, or disabled.[6]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  Eligibility for Medicaid through this track is limited to individuals accessing HCBS through the Aged and Disabled program (CSR, 2022a; CMS, 2024b). Individuals requiring Medicaid eligibility to access nursing facility care cannot use this eligibility track to qualify.
  - ◇ Income requirements: Monthly income may not exceed $1,388 in 2021 (MDSS, 2024b). Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical monthly benefit amounts. Additional income disregards exist if a person is enrolled in the Aged & Disabled program and has a spouse residing in the community.[12]
  - ◇ Asset requirements: Resources may not exceed $5,035 (MDSS, 2021d). Assets for this track are evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is enrolled in the Aged & Disabled program and has a spouse residing in the community.[13]
    - Asset transfer & Home equity limit: Same as eligibility track 1b.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - ◇ Other requirements
    - The applicant must be at least age 65, or age 63-64 with a physical disability
    - The applicant must be receiving or in need of LTC services through the Aged & Disabled program.
- 2c. Affordable Care Act (ACA) expansion adults
  - ◇ Income requirements: Monthly income may not exceed 138% of the FPL. In 2021 this was $1,481 for an individual and $2,003 for a household of two. See Table 2 for historical income limits.
  - ◇ Asset requirements: There is no asset test for this population.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - ◇ Other requirements
    - The applicant must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast or Cervical Cancer Treatment (BCCT): Provides MO HealthNet coverage, including long-term care, for women who are under age 65 with income up to 200% of the FPL who have been found to have breast or cervical cancer including a precancerous condition

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Personal Care Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Aged & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 or between age 63-64 with a disability. While the state intends to have enough program slots to accommodate all eligible beneficiaries, if the program reaches enrollment capacity applicants are placed on a waiting list based on need until a spot becomes available (MDSS, 2021).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- AIDS program
- Program of All-Inclusive Care for the Elderly (PACE)
- Adult Day Care program
- Brain Injury program
- Structured Family Caregiving (SFC)

- Independent Living program—from 2024

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

Home Health provides (CSR, 1993; CSR, 2023b):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are capped at 3 hours per day and 100 visits per calendar year. Until 2020 home health aide services were required to be provided concurrently with skilled nursing services (CSR, 1993b; CSR, 2020b).

Personal Care Services

Personal care services (PCS) provides (CSR, 1998e; CSR, 2023c):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Missouri provides basic and advanced PCS. Basic PCS assist with ADL and IADL support when the beneficiary does not require devices and procedures related to altered body functions. Advanced PCS are provided to beneficiaries who require devices and procedures related to altered body functions. Total monthly PCS are subject to a cost limit of 60% of the average monthly cost of care in a nursing facility.

Nursing Facility Care

This program does not provide home care.

Aged & Disabled

The Aged & Disabled program provides (MDSS, 1992b; MDSS, 2021b; CMS, 2023a):

- Homemaker services: Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

Community care

Community care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services, Personal Care Services, Nursing Facility Care

These programs do not provide community care.

Aged & Disabled

The Aged & Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (MDSS, 1995; MDSS, 2013; MDSS, 2021b; MDSS, 2023a).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services, Personal Care Services, Aged & Disabled

These programs do not provide residential care.

Nursing Facility Care

Missouri Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs (CSR, 1998d; CSR, 2023a). Services may include the following:

- Physician services

- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Missouri's largest home and community-based services (HCBS) program.

Missouri Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Aged & Disabled

The Aged & Disabled program provides services in addition to those offered under the state plan, unless otherwise noted (MDSS, 2013; MDSS, 2021b; CMS, 2023a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
    - ◇ Basic respite: Maintenance and supervisory services provided to beneficiaries with nonskilled needs
    - ◇ Advanced respite: Provided to beneficiaries who are bedridden, have behavioral disorders, or have health problems who require monitoring and assistance

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Division of Aging (DA) within the Department of Social Services (DSS) until 2001 when it was moved under the Department of Health and Senior Services (DHSS) and renamed the Division of Senior Services. In 2018, the Division of Senior Services was renamed the Division of Senior and Disability Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by a registered nurse, and home health aide services are provided by home health aides under the supervision of a registered nurse. Both registered nurses and home health aides provided services through home health agencies certified by the DSS until 2001, and by the DHSS from 2002 (CSR, 1993b; CSR, 1998a; CSR, 2021; CSR, 2023b).

Personal Care Services

Personal care services are provided by personal care aides under the supervision of a registered nurse employed by DSS or DHSS-certified provider agencies (CSR, 1998e; CSR, 2023c).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of DSS or DHSS-certified nursing facilities (42 CFR 483.30).

Aged & Disabled

Aged & Disabled program services are provided by DSS or DHSS-certified service providers, with respite, homemaker, and chore services provided by trained service staff under the supervision of registered nurses (CSR, 2002a; MDSS, 2023a).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. The beneficiary must be homebound, defined as having a medical condition that restricts their ability to leave the house except with the aid of assistive devices, and there must be no other caregiver available to provide the services needed (CSR, 1993). The homebound requirement was eliminated in 2010, and replaced with the requirement that services be necessary to maintain the beneficiary at home (CMS, 2010; CSR, 2023b).

Personal Care Services

The beneficiary must require a nursing facility level of care (NFLOC), and services must be medically necessary as an alternative to institutional care. An NFLOC is met if the individual receives at least 18 points on the state level of care assessment (CSR, 1998b; CSR, 1998e; CSR, 2023c).

Nursing Facility Care

The beneficiary must meet an NFLOC by satisfying the same LOC determination and point threshold described under Personal Care Services, and by exhibiting both physical and mental impairment such that they require skilled nursing care (CSR, 2001; CSR, 2022b).

Aged & Disabled

The beneficiary must meet an NFLOC by satisfying the same LOC determination and point threshold described under Personal Care Services, and by having their need for at least one program service per month prior authorized (MDSS, 1992b; MDSS, 2021b).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (CSR, 1993b; CSR, 2023b; 42 CFR 484.55).

Personal Care Services

NFLOC is recertified through an in-home assessment as needed, in order to redetermine the beneficiary's need for services or adjust the type or amount of services needed (CSR, 1998e; CSR, 2023c).

Nursing Facility Care

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (CSR, 2001; CSR, 2022b).

After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition (42 CFR 483.128), and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20).

Aged & Disabled

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (MDSS, 2013; MDSS, 2021b).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care, Personal Care Services

There is no age requirement.

Aged & Disabled

The individual must be at least age 65, or age 63-64 with a physical disability (MDSS, 2013; MDSS, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary to maintain the beneficiary at home, and there can be no other caregiver available to provide the services needed (CSR, 2023b).

Personal Care Services

The beneficiary must require a nursing facility level of care (NFLOC) by scoring at least 18 points on a screening tool that assesses the beneficiary's cognitive and functional impairment as well as care needs across 12 level of care (LOC) categories (CSR, 1998b; MDHSS, 2021a). See Box 7 for assessment and scoring details for the following LOC categories: behavioral, cognition, mobility, eating, and toileting. See Box 8 for LOC categories: bathing, dressing and grooming, rehabilitative services, treatments, meal preparation, medication management, and safety.

In addition to requiring an NFLOC, in order to qualify for personal care services (PCS) a beneficiary must also be capable of living independently with PCS (CSR, 2023c).

Nursing Facility Care

To qualify for care in a skilled nursing facility the beneficiary must meet an NFLOC and exhibit both physical and mental impairment such that skilled nursing services are required to address their care needs (CSR, 2022b). NFLOC is determined using the same criteria described above under PCS.

Aged & Disabled

To qualify for Aged & Disabled program services, beneficiaries must meet an NFLOC and have their need for at least one program service authorized in advance of receiving program benefits (MDSS, 2021b). NFLOC is determined using the same criteria described above under PCS.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner must order home health services in accordance with a plan of care that establishes medical need for the ordered services based on an in-person assessment. The plan of care is certified using form CMS-485: Home Health Certification and Plan of Care, which collects information including functional limitations and cognitive status (CSR, 2023b; MDSS, 2023b). See Box 1 for the information collected on the CMS-485 form, and see CMS (2024) to view the full assessment form.

Personal Care Services

The beneficiary is evaluated during an in-home visit by Department of Health and Senior Services (DHSS) staff in which the beneficiary's physical, social, and functional ability to benefit from personal care services is assessed (CSR, 2023c). Care needs are evaluated using a level of care (LOC) determination tool that asssesses care needs across 12 LOC categories. An individual must score at least 18 points across the 12 categories to qualify as requiring a nursing facility level of care (NFLOC). Certain LOC

categories include an 18-point "trigger" where care needs of adequate severity automatically qualify an individual as requiring an NFLOC. See Box 7 for assessment and scoring details for LOC categories behavioral, cognition, mobility, eating, and toileting, and see Box 8 for bathing, dressing and grooming, rehabilitative services, treatments, meal preparation, medication management, and safety.

Nursing Facility Care

The beneficiary is referred to the DHSS for screening and assessment by a nursing facility or service provider, after which DHSS staff have 10 days to contact the beneficiary to conduct the screening and inform the beneficiary of their institutional as well as home-based options (CSR, 2022b). Pre-admission screening is conducted using Level One Nursing Facility Pre-Admission Screening Form DHSS-DRL-110, which is submitted to the DHSS along with Nursing Facility Level of Care Assessment Form DHSS-DRL-109 used to evaluate and certify the beneficiary's level of care needs using the same criteria described under Personal Care Services. See Box 7 for assessment and scoring details for LOC categories behavioral, cognition, mobility, eating, and toileting, and see Box 8 for bathing, dressing and grooming, rehabilitative services, treatments, meal preparation, medication management, and safety. See MDHSS (2021d) to view the full assessment form.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the MDS. See Box 5 for more information on the PASRR, which is conducted using form DRL-110 during this policy period, and Box 6 for the MDS.

Aged & Disabled

Potential beneficiaries are referred for home and community-based services (HCBS) by submitting a Home and Commnity Based Services Referral Form to the Division of Senior and Disability Services (DSDS) to initiate the intake process. DSDS staff confirm medicaid eligibility and prescreen the beneficiary for potential program eligibility. They then schedule an in-person visit within 15 days of receiving the initial referral to conduct a full care needs assessment outlined under Personal Care Services in order to determine if the beneficiary meets the 18 point threshold required to satisfy NFLOC (MDHSS, 2022b).[7] The results of the assessment are submitted online using a state HCBS web tool or using the General Health Evaluation & Level of Care Recommendation form. Starting in 2023 the prescreening step is no longer required, and program applicants are contacted directly by the DSDS to schedule their initial InterRAI-HC assessments (MDSS, 2021b).

Evaluators

Evaluators vary by LTC health benefit program. The details of the four largest programs are summarized below.

Home Health Services

A licensed physician or approved practitioner (e.g., nurse practitioner, clinical nurse specialist, or physician's assistant) must order home health services, develop the plan of care, and periodically review the plan of care (CSR, 2023b).

Personal Care Services

The Department of Health and Senior Services (DHSS) is responsible for assessing, approving, and case managing beneficiaries for personal care services based on an in-home level of care assessment. For advanced personal care services, the plan of care must be developed by the service provider's registered nurse in collaboration with the DHSS (CSR, 2023c).

Nursing Facility Care

Level of care evaluations are conducted by the beneficiary's attending physician, and are reviewed and assessed by DHSS staff or designated agents (CSR, 2022b).

Aged & Disabled

Division of Senior and Disability Services (DSDS) staff receive referrals for program services, determine if they are appropriate candidates for further screening, and conduct an in-person visit for an initial level of care evaluation (MDHSS, 2022a; MDHSS, 2022b).

Benefit limitations

Can you mix LTC benefits?

All Missouri Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the four largest programs.

Medicaid

As required by federal law, Missouri enforces Estate Recovery. The acceptance of Medicaid in Missouri creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (RSMo 473.398; 42 USC 1396p(b)(1)).

Home Health Services

Available Missouri state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2021, the PNA was $50 per month (CSR, 2022a).

Aged & Disabled

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Missouri Federal Medical Assistance Percentage (FMAP) for Medicaid (1992-2024)

Fiscal Year	FMAP
1992	60.84%
1993	60.26
1994	60.64
1995	59.85
1996	60.06
1997	60.04
1998	60.68
1999	60.24
2000	60.51
2001	61.03
2002	61.06
2003	62.71
2004	63.68
2005	61.15
2006	61.93
2007	61.60
2008	62.42
2009	72.26
2010	74.43
2011	70.07
2012	63.45
2013	61.37
2014	62.03
2015	63.45
2016	63.28
2017	63.21
2018	64.61
2019	65.40
2020	70.30
2021	71.16
2022	72.56
2023[1]	70.79
2024	66.45

Source: U.S. DHHS (2024)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201).

[1]The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Missouri Medicaid Income Limits (1992-2024)

Year	209(b) (Individual)	209(b) (Couple)	209(b) income standard	HCB income limit (Individual)	138% FPL (Individual)	138% FPL (Couple)
1992	$422	$633	SSI			
1993	434	652	SSI	$750		
1994	446	669	SSI	770		
1995	458	687	SSI	800		
1996	470	705	SSI	800		
1997	484	726	SSI	800		
1998	494	741	SSI	800		
1999	500	751	SSI	800		
2000	513	769	SSI	800		
2001	531	796	SSI	928		
2002	591	796	80% FPL	952		
2003	599	808	80% FPL	965		
2004	698	937	90% FPL	985		
2005	798	1,069	100% FPL	1,012		
2006	694	935	85% FPL	1,053		
2007	723	970	85% FPL	1,088		
2008	737	992	85% FPL	1,113		
2009	767	1,032	85% FPL	1,178		
2010	767	1,032	85% FPL	1,178		
2011	771	1,042	85% FPL	1,178		
2012	791	1,072	85% FPL	1,220		
2013	814	1,099	85% FPL	1,241		
2014	827	1,114	85% FPL	1,260		
2015	834	1,128	85% FPL	1,281		
2016	842	1,135	85% FPL	1,281		
2017	854	1,150	85% FPL	1,285		
2018	860	1,166	85% FPL	1,311		
2019	885	1,198	85% FPL	1,348		
2020	904	1,221	85% FPL	1,370		
2021	912	1,234	85% FPL	1,388	$1,481	$2,003
2022	963	1,297	85% FPL	1,470	1,563	2,106
2023	1,033	1,397	85% FPL	1,598	1,677	2,268
2024	1,067	1,448	85% FPL	1,649	1,732	2,351

Source: SSA (2024b), HHS (2024)

Notes: Income limits for individuals and couples are monthly. Income limits using the HCB income limit (eligibility track 2a. Institutional Rules) and 138% of the FPL (eligibility track 2c. ACA Expansion Adults) begin in 1993 and 2021 respectively, corresponding to Missouri's implementation of each eligibility track.The 209(b) income limit was set at the maximum Supplemental Security Income (SSI) benefit amount until 2002, when the income limit was increased to 80% of the FPL. The income limit for this track was raised to 90% FPL in 2003 and 100% FPL in 2004, and decreased to 85% in 2005. Figures in this table correspond to state fiscal years.

Table 3: MO HealthNet Resource Limits (2017-2024)

Year	Resource Limit (Individual)	Resource Limit (Couple)
Before Jul. 2017	$999.99	$2,000
Jul. 2017 — Jun. 2018	2,000	4,000
Jul. 2018 — Jun. 2019	3,000	6,000
Jul. 2019 — Jun. 2020	4,000	8,000
Jul. 2020 — Jun. 2021	5,000	10,000
Jul. 2021 — Jun. 2022	5,035	10,070
Jul. 2022 — Jun. 2023	5,302	10,604
Jul. 2023 — Jun. 2024	5,726	11,452
Jul. 2024 — Jun. 2025	5,909	11,818

Source: MDSS (2022), MDSS (2024a), MDSS (2024c)
Notes: From FY22, asset limits increase each year with inflation.

Box 1: Form HCFA-485 / CMS-485 Home Health Certification and Plan of Care

Form HCFA-485 (1992-2001) / CMS-485 (2001-present) are used by physicians to certify medical necessity for home health services, and to build and certify a Medicaid home health services recipient's plan of care. The form collects the following information:

- Relevant diagnoses
- Mental, psychosocial, and cognitive status
- Types of services, supplies, and equipment required
- Frequency and duration of visits to be made
- Prognosis
- Rehabilitation potential
- Funcional limitations
- Activities permitted
- Nutritional requirements
- Medications and treatments
- Safety measures to protect against injury
- Description of risk for emergency department visits and hospital readmission, and necessary interventions to address underlying risk factors
- Patient and caregiver education and trainings, patient-specific interventions and training with measurable outcomes and goals
- Any additional items or information the home health agency or physician may choose to include

Source: DHHS (1994), CMS (2024)
Notes: Form HCFA-485 was renamed form CMS-485 in 2001 when the Health Care Financing Administration (HCFA) within the federal Department of Health and Human Services was renamed the Centers for Medicare and Medicaid Services (CMS).

Box 2: Missouri NFLOC Criteria (1992-2024) Part 1

An applicant qualifies for NFLOC by meeting an assessed points threshold that is scored across the following 9 categories:

- Monitoring: observation and assessment of physical and/or mental condition
  - 0 pts: none or routine monitoring, nurse visits (services delivered intermittently/as needed, checking vitals), daily or as needed monitoring by neighbors/friends
  - 3 pts: minimal monitoring and periodic assessment by physician, nurse, or mental health professional no less than once per month to monitor and assess specific mental/physical condition, includes telemonitoring for stable condition
  - 6 pts: moderate monitoring and recurring assessment by physician, nurse, or mental health professional, same condition as 3 pts except monitoring and assessment for unstable condition
  - 9 pts: maximum monitoring, same conditions as 3 and 6 pts except monitoring is for an unstable condition that requires intensive monitoring by licensed personnel
- Medications: drug regimen of all physician-ordered prescription and amount of assistance needed to administer medications properly
  - 0 pts: no medications prescribed by a physician, irregular use of prescribed PRN medication
  - 3 pts: prescription or physician-ordered over-the-counter medications for stable condition, prescribed regular use of as needed medication, no assistance needed
  - 6 pts: prescription or physician-ordered over-the-counter medications for stable condition and requires moderate supervision, requiring daily monitoring by licensed personnel
  - 9 pts: prescription or physician-ordered over-the-counter medications for unstable condition and requires maximum supervision, total assistance is needed, drug regime complex or requiring professional observation and assessment
- Treatments: a systematized course of nursing procedures ordered by the physician and intended to treat a specific medical condition
  - 0 pts: no treatments ordered
  - 3 pts: minimal physician-ordered treatments, non-routine preventative measures, caring for skin disorders requiring less than daily dressings
  - 6 pts: moderate physician-ordered treatments requiring daily attention by licensed personnel even if done by family/caregiver, caring for skin disorders requiring daily dressings, catheter or ostomy maintenance care, oral suctioning/stabilized dialysis/daily breathing treatments, PRN oxygen used within 30 days of assessment
  - 9 pts: maximum physician-ordered treatments requiring direct supervision by licensed personnel even if done by family/caregiver, intratracheal suctioning for ventilator/respirator care, chemotherapy/radiation/unstable dialysis, continuous oxygen, new or unregulated ostomy care maintenance of cystostomy, transfusions
- Restorative: specialized services provided by trained and supervised individuals to help maintain optimal functioning potential, including but not limited to teaching passive range of motion, bowel/bladder training, self-administration of medicine, and daily living skills (cooking, budgeting, personal grooming, self-directing care)
  - 0 pts: no restorative services being received
  - 3 pts: minimal training/teaching activities, goal to maintain current functioning level (e.g., teaching independent living skills)
  - 6 pts: moderate training/teaching activities, goal to help restore individual to a higher level of functioning (e.g., teaching stroke patient to use adaptive eating device or a diabetic to fill syringes and give injections)
  - 9 pts: maximum training/teaching activities, goal to help restore participant to a higher level of functioning (intensive activities requiring professional licensed nurse or physician supervision/direct service)
- Rehabilitative: restoration of a former or normal state of health through medically oriented therapeutic services (physical therapy, occupational therapy, speech therapy, audiology)
  - 0 pts: no physician-ordered therapies
  - 3 pts: therapy ordered one time weekly
  - 6 pts: therapy ordered 2-3 times weekly
  - 9 pts: therapy ordered 4 times weekly or more

Source: CSR (2001)

Notes: The point threshold required to qualify for NFLOC varied during this time period. Beneficiaries required an assessed point score of 18 until July 2015 when the threshold was raised to 21 points. The threshold was raised again to 24 points in 2017, and was lowered back down to 18 in 2021. This box lists the first 5 out of 9 level of care assessment categories. See Box 3 for the remaining 4 assessment categories.

Box 3: Missouri NFLOC Criteria (1992-2024) Part 2

An applicant qualifies for NFLOC by meeting an assessed points threshold that is scored across the following 9 categories:

- Personal Care: amount and frequency of assistance required for activities of daily living (ADLs) dressing, bathing, oral and personal hygiene, grooming, and bowel and bladder functions
  - 0 pts: requires no assistance with personal care needs and has bowel and bladder control, refuses to bathe but is able, able but prefers assistance with hair care
  - 3 pts: occational or minimal assistance required for personal care needs including oversight and cuing, infrequent incontinence (once a week or less)
  - 6 pts: moderate assistance required with personal care needs, requires close supervision in that someone must be present to assist constantly with grooming and bathing needs, frequent incontinence (2-3 times per week)
  - 9 pts: maximum assistance required in that another individual performs all personal care needs, continuous incontinence
- Dietary: nutritional requirements and need for assistance or supervision with meals, physician-ordered special diets
  - 0 pts: no assistance required to eat, prepares meals independently, no physican ordered diet, meals eaten at a nutrition site or prepared by a facility which the participant could have prepared, minor modification (low-fat, low-sugar, low-sodium, low cholesterol, etc.), mechanical alterations (including soft drinks, liquid supplements)
  - 3 pts: minimum assistance required for dietary needs including oversight and cuing, physician-ordered calculated diet prescribed for a specific stable condition
  - 6 pts: moderate assistance required for dietary needs, someone must be present at all times to supervise or to actually feed, physician ordered calculated diet prescribed for an unstable condition
  - 9 pts: maximum assistance required for dietary needs, unable to articipate in eating, requires enteral feedings or parenteral fluids (tube feeding, IV)
- Mobility: ability to move from place to place, taking into account assistive devices and human assistance needed
  - 0 pts: may use assistive devices, but is consistently capable of negotiating without human assistance
  - 3 pts: minimal assistance required, needs periodic human assistance to get around, independent in wheelchair after assistance given getting in and out of chair
  - 6 pts: moderate assistance required, cannot ambulate without direct human assistance, requires human assistance with ambulation (including with use of assistive devices)
  - 9 pts: maximum assistance required, totaly dependent on other persons to move, uable to ambulate or participate in the ambulation process
- Behavioral and Mental Condition: amount of assistance needed due to behavior or mental problems
  - 0 pts: well oriented and requires little or no assistance from others; memory intact
  - 3 pts: minimum behavioral assistance needed, periodic supervision due to some memory lapse, assistance required due to occasional forgetfulness, generally relates well to others but needs occasional emotional support
  - 6 pts: moderate behavioral assistance and supervision required due to disorientation, mental or developmental disabilities, uncooperative behavior
  - 9 pts: maximum behavioral assistance and extensive supervision required due to psychological/developmental disabilities or traumatic brain injuries resulting in confusion, incompetence, hyperactivity, severe depression, suicidal tendency, hallucinations, delusions, bizarre behavior; verbally or physically combative; incapable of self-direction; danger to self or others

Source: CSR (2001)

Notes: The point threshold required to qualify for NFLOC varied during this time period. Beneficiaries required an assessed point score of 18 until July 2015 when the threshold was raised to 21 points. The threshold was raised again to 24 points in 2017, and was lowered back down to 18 in 2021. This box lists the last 4 out of 9 level of care assessment categories. See Box 2 for the first 5 assessment categories.

Box 4: Form DA-124A/B: Initial Assessment - Social and Medical (1992-2024)

Form 124A/B is used to assess eligibility for nursing facility care, and includes both a social and a medical assessment component. Nursing facility level of care (NFLOC) is determined using section 16 of the form according to the criteria outlined in Box 2 and Box 3. The form collects the following information:

- A. Social Assessment
  - Personal information (name, date of birth, address, legal guardian/designated contact)
  - Education level
  - Was person receiving care prior to nursing facility placement?
- B. Medical Assessment
  - Vitals: Height, weight, blood pressure, pulse, date of last medical exam
  - Recent medical incidents: E.g., surgery, fracture, head injury, cerebrovascular accident
  - Lab tests, prescriptions, medical diagnoses
  - Potential problem areas
  - Stability: Improving, stable, deteriorating, unstable
  - Mental status: Oriented to person/place/time, thinks clearly, lethargic, alert, memory
  - Behavioral information: Confused, withdrawn, hyperactive, wanders, suspicious, combative, supervised for safety, causes management problems, controlled with medications
  - Functional impairment: Vision, hearing, speech, ambulation, manual dexterity, toileting, path to safety
  - Assessed needs: Mobility, dietary, restorative services, monitoring, medication, behavioral condition, treatments, personal care, rehabilitative services
  - Potential for rehabilitation: Good/fair/poor

Source: MDSS (1998), MDHSS (2021b)

Box 5: Preadmission Screening and Resident Review (PASARR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASARR). The purpose of the PASARR is to rpevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level I screening), and a final determination. All applicants of Medicaid-certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASARR evaluation.

Source: 42 CFR 483.100-138

Box 6: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: CMS (2023b)

Box 7: Missouri Nursing Facility Level of Care (NFLOC) Criteria (2021-2024) Part 1

An applicant qualifies for NFLOC with an assessed point score of 18 or higher across the following categories:

- Behavioral: receives monitoring for a mental condition, exhibits mood or behavior symptoms (wandering, physical abuse, inappropriate or disruptive behavior, resists care), or exhibits psychiatric conditions (abnormal thoughts, delusions, hallucinations)
  - 0 pts: stable mental condition, no mood or behavior symptoms observed AND no reported psychiatric conditions
  - 3 pts: stable mental condition monitored by a physician or licensed mental health professional at least monthly OR behavior symptoms exhibited in past, but not currently present OR psychiatric conditions exhibited in past, but not recently present
  - 6 pts: unstable mental condition monitored by a physician or licensed mental health professional at least monthly OR behavior symptoms are currently exhibited OR psychiatric conditions are recently exhibited
  - 9 pts: unstable mental condition monitored by a physician or licensed mental health professional at least monthly AND behavior symptoms are currently exhibited OR psychiatric conditions are currently exhibited
- Cognition: has issues in one or more of the following areas—cognitive skills for daily decision making, memory or recall ability (short-term, procedural, situational), disorganized thinking/awareness, ability to understand others or to be understood
  - 0 pts: no issues with cognition AND no issues with memory, mental function, or ability to be understood/understand others
  - 3 pts: displays difficulty making decisions in new situations or occasionally requires supervision in decision making AND has issues with memory, mental function, or ability to be understood/understand others
  - 6 pts: displays consistent unsafe/poor decision making requiring reminders, cues, or supervision at all times to plan, organize, and conduct daily routines AND has issues with memory, mental function, or ability to be understood/understand others
  - 9 pts: rarely or never has the capability to make decisions OR displays consistent unsafe/poor decision making or requires total supervision requiring reminders, cues or supervision at all times to plan, organize and conduct daily routines AND rarely or never understood/able to understand others
  - 18 pts (TRIGGER): no discernible consciousness, coma
- Mobility: takes into account primary mode of locomotion, the amount of assistance needed with locomotion (how moves walking or wheeling, how much assistance needed in wheelchair), and bed mobility (transition from lying to sitting, turning, etc.)
  - 0 pts: no assistance needed OR only set up or supervision needed
  - 3 pts: limited or moderate assistance needed, i.e., performs more than 50% of tasks independently
  - 6 pts: maximum assistance needed, i.e., needs two or more individuals or more than 50% weight-bearing assistance OR total dependent for bed mobility
  - 18 pts (TRIGGER): bedbound OR totally dependent on others for locomotion
- Eating: takes into account amount of assistance needed with eating and drinking, including intake of nourishment by other means (e.g. tube feeding or total parenteral nutrition [TPN]) and whether the participant requires a physician-ordered therapeutic diet
  - 0 pts: no assistance needed AND no physician ordered diet
  - 3 pts: physician ordered therapeutic diet OR set up, supervision, or limited assistance needed with eating
  - 6 pts: moderate assistance needed with eating, i.e., performs more than 50% of task independently
  - 9 pts: maximum assistance needed with eating, i.e., requires an individual to perform more than 50% for assistance
  - 18 pts (TRIGGER): totally dependent on others
- Toileting: amount of assistance needed with toileting
  - 0 pts: no assistance needed OR only set up or supervision needed
  - 3 pts: limited or moderate assistance needed, i.e., performs more than 50% of tasks independently
  - 6 pts: maximum assistance, i.e., requires two or more individuals or more than 50% of weight-bearing assistance
  - 9 pts: total dependence on others

Source: CSR (2022b), MDHSS (2024b)

Notes: Beneficiaries must score at least 18 points to qualify as requiring an NFLOC. This box lists the first 5 out of 12 level of care assessment categories. See Box 8 for the remaining 7 categories.

Box 8: Missouri Nursing Facility Level of Care (NFLOC) Criteria (2021-2024) Part 2

An applicant qualifies for NFLOC with an assessed point score of 18 or higher across the following categories:

- Bathing: amount of assistance needed with bathing, including taking a full body bath/shower and transferring in and out of the bath/shower
  - 0 pts: no assistance needed OR only set up or supervision needed
  - 3 pts: limited or moderate assistance needed, i.e., performs more than 50% of tasks independently
  - 6 pts: maximum assistance, i.e., requires two or more individuals, more than 50% of weight-bearing assistance, OR total dependence on others
- Dressing and Grooming: amount of assistance needed to dress, undress, and complete daily grooming tasks
  - 0 pts: no assistance needed OR only set up or supervision needed
  - 3 pts: limited or moderate assistance needed, i.e., performs more than 50% of tasks independently
  - 6 pts: maximum assistance, i.e., requires two or more individuals, more than 50% of weight-bearing assistance, OR total dependence on others
- Rehabilitative Services: has medically ordered rehabilitative services (physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, audiology)
  - 0 pts: none of the above therapies ordered
  - 3 pts: any of the above therapies ordered 1 time per week
  - 6 pts: any of the above therapies ordered 2-3 times per week
  - 9 pts: any of the above therapies ordered 4 or more times per week
- Treatments: the applicant requires any of the following—catheter/ostomy care, alternate modes of nutrition (tube feeding, TPN), suctioning, ventilator/respirator, wound care (skin must be broken)
  - 0 pts: none of the above treatments were ordered by the physician
  - 6 pts: one or more of the above treatments was ordered by the physician requiring daily attention by a licensed professional
- Meal Preparation: amount of assistance needed to prepare a meal, including planning, assembling ingredients, cooking, and setting out food and utensils
  - 0 pts: no assistance needed OR only set up or supervision needed
  - 3 pts: limited or moderate assistance needed, i.e., performs more than 50% of tasks
  - 6 pts: maximum assistance, i.e., an individual performs more than 50% of tasks for the applicant OR total dependence on others
- Medication Management: amount of assistance needed to safely manage medications
  - 0 pts: no assistance needed
  - 3 pts: set up help needed OR supervision needed OR limited or moderate assistance needed, i.e.,performs more than 50% of tasks
  - 6 pts: maximum assistance needed, i.e.,an individual performs more than 50% of tasks for the applicant OR total dependence on others
- Safety: takes into account problems with visual impairment, falling, or balance, as well as institutionalization within the last five years (including nursing facility) and age 75 years or over
  - 0 pts: no difficulty or some difficulty with vision AND no falls in last 90 days AND no recent problems with balance
  - 3 pts: severe difficulty with vision (sees only lights and shapes) OR has fallen in the last 90 days OR has current problems with balance OR preliminary score of 0 AND Age OR institutionalization
  - 6 pts: no vision OR has fallen in last 90 days AND has current problems with balance OR preliminary score of 0 AND age AND institutionalization OR preliminary score of 3 AND age OR institutionalization
  - 9 pts: preliminary score of 6 AND institutionalization
  - 18 pts (TRIGGER): preliminary score of 6 AND age OR preliminary score of 3 AND age AND institutionalization

Source: CSR (2022b), MDHSS (2024b)

Notes: Beneficiaries must score at least 18 points to qualify as requiring an NFLOC. This box lists the last 7 out of 12 level of care assessment categories. See Box 7 for the first 5 categories.

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): ADHC is a community-based long term care benefit that provides nursing care, personal care, social, nutritional, and therapeutic services, typically furnished in a community center for four or more hours per day at least once per week.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the

June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Aged and Disabled program: The Aged and Disabled program in Missouri offers home and community-based services to individuals aged 63 or over who require a nursing facility level of care. The program is authorized under section 1915(c) of the Social Security Act.

Central Registry Unit: The Central Registry Unit operated by the Division of Aging serves as a clearinghouse for receipt of long-term care service referrals, screening individuals for potential program eligibility who are then referred to the Division of Aging for more a comprehensive needs assessment that determines program eligibility and services needed.

Chore services: Chore services are household tasks necessary to maintain a safe and habitable home environment provided intermittently as needed by a trained homemaker. Chore services include: light cleaning (e.g., washing walls, windows, rugs), pest and rodent control (e.g., spraying the home with over-the-counter supplies, setting traps), and outside maintenance including lawn mowing or snow removal.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

CMS-485: Home Health Certification and Plan of Care: Federal form used by home health agencies to certify the plan of care required to authorize home health services. This form is typically used to certify home health services under Medicare. Missouri applies its Medicare home health certification criteria and process to its Medicaid home health program, and uses the same form to authorize services.

DA-1 Form: Prescreening form used to assess a beneficiary's potential eligibility for home and community-based services under the Aged & Disabled program.

DA-13 Form: Form used in the initial prescreening process for potential Medicaid nursing facility care beneficiaries to document eligibility as well as certify that the individual has been informed of their alternatives to receive care in a home or community-based environment, but chooses to enter a long-term care facility.

DA-124A/B Form: Screening form used to assess a potential beneficiary's eligibility for Medicaid nursing facility care.

Department of Health and Senior Services (DHSS) : The DHSS is responsible for supervising and managing public health programs and functions, including the licensing of home health agencies. Since 2001 the DHSS has been responsible for overseeing Medicaid long-term care (LTC) including certifying LTC facilities and conducting screenings and level of care determinations for LTC service eligibility, after the Division of Aging was transferred under its authority from the Department of Social Services.

Division of Aging (DA): Division within the Department of Social Services responsible for licensing and overseeing Medicaid LTC providers.

Division of Senior and Disability Services (DSDS): From 2018 the Division of Social Services changed its name to the Division of Senior and Disability Services, and continued to be responsible for coordinating state public assistance and child welfare services.

Division of Social Services (DSS) : The DSS is responsible for coordinating state public assistance and child welfare services, including administering Missouri's Medicaid program.

Division of Medical Services (DMS) : The DMS is the specific division within the DSS that is responsible for administering Missouri's Medicaid program. In 2008 the DMS was renamed the MO HealthNet Division.

DRL-109: Assessment form used after 2021 to certify nursing facility level of care (NFLOC) for institutional care recipients.

DRL-110: Prescreening form used to conduct the federally mandated Pre-Admission Screening and Resident Review (PASRR) screening for mental illness or intellectual disability prior to authorizing a beneficiary's eligibility for Medicaid nursing facility care.

Eligibility Track 1b. 209(b) States: The Social Security Act provides states the authority to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program. States that elect this option are called 209(b) states. Because eligibility for SSI does not guarantee Medicaid eligibility in a 209(b) state, these states do not cover the mandatory SSI Beneficiaries group. Instead, 209(b) states can impose more restrictive criteria through the mandatory 209(b) group. A person receiving SSI can still

be eligible for Medicaid in the mandatory 209(b) group, but that person must also meet the more restrictive eligibility requirements imposed by the state.

Eligibility Track 2a. Institutional Rules for People Receiving LTC: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states, including Missouri, do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). Missouri only extends this track to HCBS recipients in the Aged and Disabled program.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual typically must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. States are required to seek recovery of payments from the individual's estate for nursing facility services, and for individuals age 55 or older for home and community-based services and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. Missouri does not limit recovery to the federally required minimum services and seeks recovery of payments for all medical assistance received.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Services provided in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Homebound: An individual is considered homebound if they have a condition due to illness or injury that makes leaving the home medically inadvisable.

Homemaker services: General household activities provided by a trained homemaker when the beneficiary is unable to manage home care for themselves, or when others who are regularly responsible for these activities are temporarily absent. Homemaker services can include meal preparation, household cleaning, shopping for essential items, performing errands (e.g., posting mail, picking up prescriptions), and reading or writing essential correspondence.

IM-54A: Form used in the home and community-based services authorization process to coordinate an individual's enrollment in the Aged and Disabled Program between the Department of Social Services and the Department of Health and Senior Services.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money,

shopping for groceries, performing housework, and using a telephone.

InterRAI-HC: A globally standardized assessment instrument also known as the MDS-HC that is designed to comprehensively assess an individual for functional, cognitive, psychosocial, and medical impairments and care needs.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid state plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Missouri Care Options (MCO): State program offering home and community long-term care services to adults who are Medicaid eligiible, or potentially Medicaid eligible, and in need of assistance. The program is designed to help individuals live as independently as possible, and offers transition services for institutional care recipients who qualify for care in a home or community-based setting.

MO HealthNet Division : Formerly the Division of Medical Services, the MO HealthNet Division is the division within the Department of Social Services tasked with administering the state Medicaid program, referred to as MO HealthNet after 2008.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing Facility Level of Care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Permanently Residing Under Color of Law (PRUCOL): An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by

institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

Private Duty Nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent.

Program of All-Inclusive Care for the Elderly: A federally authorized program that provides comprehensive medical and social services to elderly individuals requiring a nursing facility level of care. PACE programs are typically provided under Medicare, however states can elect to provide PACE services to Medicaid beneficiaries as an optional benefit. Enrollment in PACE programs is typically capped at a relatively low number of participatns.

Protected Income Level (PIL): The income limit Medically Needy applicants must spend down to meet. Federal rules require PILs to be no higher than 133 percent of the maximum state Aid to Families and Dependent Children (AFDC) level in effect as of July 16, 1996.

Qualified Income Trust (QIT): A Qualified Income Trust (QIT), or Miller Trust, is an irrevocable trust that allows individuals with excess income to qualify for Medicaid benefits. Each month, the beneficiary's excess income is deposited in the QIT, and a designated trustee can use these funds for limited purposes that include the beneficiary's monthly personal needs allowance, residential care facility costs, community spouse allocations, and any other care-related expenses. When the beneficiary passes away, any remaining funds in the account are claimed by the State.

Respite care: Services provided to participants who are unable to care for themselves, furnished on a short-term basis because of the absence or need of relief for those persons normally providing care for the participant.

Section 1915(c) Waiver: Section 1915(c) of the Social Security Act gives the Secretary of HHS the authority to approve programs allowing states to offer home- and community-based services to Medicaid beneficiaries who need long-term care and who would otherwise be institutionalized. The program waives Medicaid comparability requirements, meaning that states can tailor the services to specific groups of enrollees and their needs.

Skilled Nursing Facility (SNF): A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Spend down: 209(b) states are required to allow individuals aged 65 and older, or who have blindness or a disability, to spend down their income to qualify for Medicaid. They can do this either by offering eligibility track 3a. for medically needy individuals, or by allowing individuals to spend down their income by incurring healthcare costs or preapproved deductions (e.g., state supplementary payments, spousal support payments) to meet the state's track 1b. mandatory coverage group income standard. Missouri allows individuals to spend down to their track 1b. income standard, and since 2002 has allowed individuals the option of either spending down by incurring approved expenses or by paying excess income directly to the Department of Health and Senior Services.

Structured Family Caregiving: Provides attendant and homemaker services, as well as escorting to doctor's appointments and community activities to beneficiaries over age 21 who have been diagnosed with Alzheimer's or related disorders, who are eligible for Medicaid, and who meet a nursing facility level of care (NFLOC).

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means.

Notes

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1. Some SSI recipients in states receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. Missouri only provides State Supplementary Payments to aged, blind, or disabled individuals who reside in non-Medicaid nursing homes or residential care facilities. See SSA (2011) for more information.

2. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the MMNA in Missouri ranged between $984-$1,718 per month. The MMNA is calculated by determining one half of the couple's combined income. If the community spouse's share of income falls within this range they may retain their income, if their share falls under this range they may retain the minimum, and if their share falls above this range they may retain the maximum. This standard increases annually with inflation.

3. Spousal consideration for assets: The community spouse is able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $13,740-$68,700 in 1992. In Missouri, the CSRA is determined by calculating one half of the couple's combined assets. If this amount falls below the range the spouse may retain the minimum and if it falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.

4. In 1992 the look back period was 30 months prior to the date of application for all assets. In 1993 the look back period was extended to 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period was 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).

5. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of an permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).

6. Applicants must meet strict requirements established by the Social Security Administration used to qualify for SSI through a disability or blindness. See SSA (2024) for more information on these requirements.

7. Missouri uses the InterRAI-HC, a globally standardized home care needs assessment instrument, to determine whether beneficiaries meet the state's criteria for requiring a nursing facility level of care (NFLOC).

8. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2002, the MMNA in Missouri ranged between $1,493-$2,232 per month. The MMNA is calculated by determining one half of the couple's combined income. If the community spouse's share of income falls within this range they may retain their income, if their share falls under this range they may retain the minimum, and if their share falls above this range they may retain the maximum. This standard increases annually with inflation.

9. Spousal consideration for assets: The community spouse is able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $17,856-$89,280 in 2002. In Missouri, the CSRA is determined by calculating

one half of the couple's combined assets. If this amount falls below the range the spouse may retain the minimum and if it falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.

10. The look back period is 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. In 2006 the Deficit Reduction Act extended the look back period to 60 months for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).
11. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.
12. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2021, the MMNA in Missouri ranged between $2,155-$3,260 per month. The MMNA is calculated by determining one half of the couple's combined income. If the community spouse's share of income falls within this range they may retain their income, if their share falls under this range they may retain the minimum, and if their share falls above this range they may retain the maximum. This standard increases annually with inflation.
13. Spousal consideration for assets: The community spouse is able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $26,076-$130,380 in 2021. In Missouri, the CSRA is determined by calculating one half of the couple's combined assets. If this amount falls below the range the spouse may retain the minimum and if it falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility.
14. The look back period is 60 months prior to the date of application for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult.

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- 1.0 (December 2024): First version.