

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201417 APRIL 10, 2014



Spend-down program eliminated

IHCP makes changes to eligibility determinations for the aged, blind, and disabled

Effective June 1, 2014, Indiana is changing the way individuals are determined eligible for coverage under the aged, blind, or disabled aid categories. Currently, aged, blind, and disabled individuals must submit an *Indiana Application for Health Coverage* to obtain coverage under the Indiana Health Coverage Programs (IHCP) even when they have already been determined eligible for the Supplemental Security Income (SSI) program by the Social Security Administration (SSA). When a disabled individual applies for IHCP coverage, he or she is subjected to additional, more restrictive criteria by the State than the SSA requires for its Social Security Disability Income (SSDI) program.

Beginning June 1, 2014, the IHCP will accept all SSA determinations of disability under the SSDI program and automatically enroll individuals determined eligible for SSI benefits by the SSA. This change will eliminate the arduous and duplicative requirement that aged, blind, and disabled applicants who receive SSI also complete a second application with IHCP. Also, neither SSI nor SSDI recipients will need to go through the State's medical review process to be determined disabled and eligible for IHCP coverage.

The transition should result in significant net savings for the state of Indiana and eliminates the unpopular Spend-down program that has caused administrative burdens for providers and members alike. In addition, actions being taken to help current aged, blind, and disabled members maintain eligibility will result in more individuals being covered as well as some members receiving more comprehensive coverage after the transition.

Information for providers explaining the impact of this transition is outlined in the [IHCP Provider Q&As](#) attached to this bulletin. General information and resources can be found on the [2014 Medicaid Disability Eligibility Changes](#) page at in.gov/fssa.

QUESTIONS?

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IHCP Provider Q&As

2014 Aged, Blind, or Disabled Eligibility Changes

The Indiana Health Coverage Programs (IHCP) is changing the way individuals are determined eligible for IHCP coverage under the aged, blind, or disabled aid categories. Referencing the section numbers of the *Social Security Act*, Indiana is transitioning from a “209(b)” state to a “1634” state. As a 209(b) state, Indiana requires aged, blind, and disabled individuals to be determined eligible based on state-specific applications for IHCP coverage and utilizes state-specific criteria for disability determinations.

Effective June 1, 2014, as a 1634 state:

- Social Security Income (SSI)-eligible individuals will be automatically enrolled in IHCP and will not need to file a separate *Indiana Application for Health Coverage*. Members with SSI will be assigned to the new MASI eligibility aid category.
- Individuals who receive Social Security Disability Income (SSDI) will not be required to undergo a separate determination of disability from Indiana’s Medical Review Team (MRT). A financial eligibility review will still be required, so these individuals will need to complete the *Indiana Application for Health Coverage*.
- IHCP will no longer be required to operate a Spend-down program; therefore this program will be eliminated effective June 1, 2014.

The information contained within this document is directed specifically toward providers. Additional information, including general 1634 transition Frequently Asked Questions (FAQs), can be found on the [2014 Medicaid Disability Eligibility Changes](http://in.gov/fssa) page at in.gov/fssa.

Impact on IHCP providers

Q.1. How does this transition impact providers?

A. The main impact of the 1634 transition on providers is the elimination of the Spend-down program. To ensure a member’s IHCP eligibility, providers will continue to verify eligibility prior to providing care. Claims will continue to be submitted as they are today; however, claims will no longer be subject to payment reduction of a member’s spend-down.

Members in institutions will still be subject to a patient liability that must be paid to the long-term care (LTC) facility. Members on Home and Community-Based Services (HCBS) waivers may be subject to a patient liability amount, depending on their income. The patient liability amount for HCBS waiver members will operate in a fashion similar to how spend-down operates today, where claims from more than one provider may be adjusted for a portion of the patient liability amount. If a patient liability applies, the provider will bill IHCP as they do today and will receive payment with the liability amount subtracted and identified on the Remittance Advice (RA). The provider will be responsible for collecting the patient liability amount from the HCBS waiver member.

Q.2. What should I tell my patients about the transition?

A. The specific impact to current Spend-down members depends on their income and whether they are eligible for Medicare. Members should expect to receive a notice from the IHCP in April 2014, explaining specifically how these changes will impact them and what actions, if any, they will need to take.

In addition to the elimination of the Spend-down program, the Indiana Family and Social Services Administration (FSSA) is making eligibility changes to existing programs that raise the income eligibility thresholds for the Medicare Savings Programs and for full Medicaid benefits for the aged, blind, or disabled aid categories. This change will mean coverage for more individuals as well as increased benefits for some members. FSSA has also created a new program to minimize the impact to participants with severe mental health issues. Information on the [Behavioral and Primary Healthcare Coordination program](#) is available at in.gov/fssa.

If you serve IHCP members that are institutionalized or on an HCBS waiver, they may need to establish a Qualified Income Trust, also known as a Miller Trust, to maintain IHCP eligibility. Members will need to establish a Miller Trust if their income is over Indiana's Special Income Limit (SIL), set at 300% of the federal benefit rate, or \$2,163 per month in 2014. If an IHCP member's notice indicates they need to establish a trust, they need to begin the process as soon as possible. The Miller Trust must be in effect prior to June 1, 2014, to maintain uninterrupted eligibility. Members to which this requirement applies have been notified about how to set up a Miller Trust. See the [Establishing a Miller Trust](#) page at in.gov/fssa for more information.

If you have a patient who is a Spend-down member and has not received a notice or has questions, instruct him or her to contact his or her FSSA Division of Family Resources (DFR) local office for assistance or call 1-800-403-0864.

Q.3 When will the Spend-down program go away?

A. Effective June 1, 2014, Spend-down will no longer exist in Indiana. Individuals who would otherwise be losing coverage due to the new changes but who file timely appeals with FSSA may still have a spend-down after June 1, 2014, until there is a hearing decision.

Impact on IHCP members

Q.4. What will be the impact on aged, blind, or disabled members enrolled in IHCP today without a spend-down obligation?

A. Members eligible under the aged, blind, or disabled aid categories without a spend-down obligation today will remain eligible.

Q.5. What will be the impact on members that have a spend-down obligation today? What happens if they are no longer covered under IHCP?

A. As detailed in the following, the impact to current IHCP members varies, depending on income (percent of the federal poverty level [FPL]) and whether they are also eligible for Medicare.

Members now on Spend-down with incomes at or below 100% of the FPL: The income eligibility threshold for full aged, blind, or disabled IHCP coverage is increasing to 100% of the FPL. All IHCP members eligible under the aged, blind, or disabled aid categories with incomes at or below this level are

eligible for full Medicaid benefits. These members will be automatically reenrolled effective June 1, 2014, and their spend-down requirement will be eliminated.

Members now on Spend-down, also eligible for Medicare, with incomes over 100% but not more than 150% of the FPL: These members will transition to IHCP coverage under the Medicare Savings Program. As such, they will continue to receive coverage for their Medicare Part B premiums and will begin to receive full coverage for all Medicare cost-sharing without having to meet a spend-down. With spend-down eliminated, these members will be QMB-only and will *not* have IHCP coverage for noncovered Medicare services, including nonemergency transportation and dental.

Members now on Spend-down, also eligible for Medicare, with incomes over 150% but not more than 185% of the FPL: These members will transition to coverage under the Medicare Savings Program and will continue to receive coverage for their Medicare Part B premiums only. Members are responsible for paying all Medicare cost-sharing and for noncovered Medicare services, including nonemergency transportation and dental.

Members now on Spend-down, also eligible for Medicare, with incomes over 185% of the FPL: These members will no longer be eligible for Medicaid and will be responsible for paying for their Medicare Part B premiums and all Medicare cost-sharing. These individuals may be eligible for additional Medicare coverage products including Medicare Advantage and Medigap policies. For free and unbiased counseling about their Medicare coverage options, individuals may call the State Health Insurance Assistance Program (SHIP) at 1-800-452-4800 (TTY: 1-866-846-0139).

Members now on Spend-down, not eligible for Medicare, with incomes over 100% of the FPL: These members will no longer be eligible for IHCP coverage. They may be eligible to receive subsidized coverage by enrolling in a qualified health plan (QHP) through the federal marketplace. Due to loss of coverage, these individuals will be allowed a 60-day special enrollment period after June 1, 2014.

Members now on Spend-down, through an HCBS waiver or who reside in an institution: Members currently participating in the Spend-down program to help pay for HCBS services or who receive institutional services with a patient liability will not lose their current benefits. However, if their monthly income exceeds Indiana's SIL, set at 300% of the federal benefit rate, or \$2,163 per month in 2014, these members need to take action immediately to establish a Miller Trust to maintain their eligibility. For members with income above this limit, a Miller Trust will need to be established by June 1, 2014, to guarantee uninterrupted eligibility.

Q.6. What will be the impact on covered services for dual (eligible for Medicaid and Medicare) and non-dual (eligible for Medicaid but not Medicare) Spend-down members with serious mental illness who currently access Medicaid Rehabilitation Option (MRO) services?

A. To ensure this vulnerable population does not lose access to critical MRO services not provided by Medicare or commercial health plans, the IHCP has developed the Behavioral and Primary Healthcare Coordination (BPHC) program. Members may maintain their IHCP coverage with no impact to covered services if they meet the eligibility requirements for this program. Please find more information about the [BPHC program](http://in.gov/fssa) at in.gov/fssa.

Q.7. Will there be any impact on members receiving services through managed care entities?

A. Yes, some members will transition from risk-based managed care to fee-for-service coverage. Members who currently receive SSI and are enrolled with a managed care entity will be transitioned to the fee-for-service MASI aid category effective June 1, 2014.

Q.8. Because the State will accept Social Security Administration (SSA) disability determinations under 1634 status, do current members need to get an SSA disability determination to maintain IHCP coverage?

A. Current members do not need a disability determination with SSA to continue IHCP coverage after the state's transition to 1634 status. However, current IHCP members who do not receive SSI or SSDI are encouraged to apply for these benefits as they may be eligible. In addition, not having a determination of disability from the SSA may jeopardize future IHCP eligibility, as most members will be required to have an SSA determination to pass their next scheduled MRT progress report.

After June 1, 2014, new IHCP applicants under the disabled aid category, who have not applied for SSA disability benefits, will be required to file an application with SSA as part of their IHCP application process.

Q.9. If a current member does not have an SSA disability determination, how will that affect future eligibility for IHCP coverage?

A. Current members will be transitioned automatically without regard to their disability status with SSA. However, during all members' next regularly scheduled MRT progress report, disability status with SSA will be taken into account. To maintain IHCP eligibility most members will need an SSA disability determination at the time of their MRT progress report. Many current members already receive disability benefits from SSA, but it is recommended that current members without SSA disability status start the SSA application process prior to their next scheduled MRT progress report.

Billing and payments

Q.10. If a member owes spend-down amounts for services rendered prior to June 1, 2014, am I able to collect the outstanding balance?

A. Yes. Providers may still collect spend-down balances owed to them for dates of service prior to the transition to 1634. Collections must occur in accordance with IHCP's member billing policies and the provider's established policies and standards.

Q.11. What do I do with a claim that was submitted for a date of service prior to June 1, 2014, that initially had no spend-down liability and is later adjusted to include a spend-down liability?

A. If a claim adjustment is later found to result in a member having a spend-down liability, you may collect the amount due from the member in accordance with IHCP's member billing policies and your established policies and standards.

Q.12. What do I do if a member's IHCP eligibility status still indicates that he or she owes a spend-down after June 1, 2014?

A. In general, there should be no spend-down amounts indicated for members after June 1, 2014. However, in cases where a member has filed an appeal, there may be instances after June 1, 2014, when a spend-down continues to be indicated. If an RA or an eligibility screen shows a spend-down requirement for dates of service on or after June 1, 2014, please contact your provider services representative to verify that the

member owes a spend- down amount for those months. Please note that members receiving HCBS waiver services may have a patient liability on or after June 1, 2014. Remittance Advices (RAs) and the Eligibility Verification System (EVS) will continue to indicate liability requirements for these individuals. Members residing in LTC facilities will still have to pay a liability to the nursing home as they do today.

Q.13. Will the process of collecting money owed to me by a member change if the member has a Miller Trust?

A. For the provider, there should be no difference in collecting payment from a member whether or not the member has a Miller Trust. Members with Miller Trusts are required to fund the trust each month to maintain eligibility. Funds in the trust may be used for approved deductions or healthcare expenses.

All collections of member liability amounts must comply with IHCP member billing policies and the provider's established policies and standards. Regardless of whether the member has a Miller Trust or not, billing members should occur as it does today. See [Chapter 4: Provider Enrollment, Eligibility, and Responsibilities](#) of the *IHCP Provider Manual* for information regarding IHCP member billing policies.

Q.14. If a patient or their caretaker refuses to pay their balance owed, will the process of recovering money owed change if the member has a Miller Trust?

A. For the provider, there should be no difference in recovering money owed from the member whether or not the member has a Miller Trust. If a member or their caretaker fails to pay their balance, your office may pursue collections of the funds in accordance with the procedures set out in [Chapter 4: Provider Enrollment, Eligibility, and Responsibilities](#) of the *IHCP Provider Manual* and your office policies and standards. Providers may or may not be aware of the existence of a Miller Trust and should pursue payment for outstanding patient liability amounts with the member or the member's caretaker as is done today.

Miller Trust establishment

Q.15. If a facility has multiple people who need to establish a Miller Trust, can the income from those multiple individuals go into one Miller Trust account?

A. A Miller Trust is a trust set up for an individual rather than for a group of people. Therefore, a trust account must be set up to receive income from a single individual, and only that individual's monthly income can be deposited. The funds that are deposited into an individual's Miller Trust account can be and are expected to be used to pay for that person's medical expenses, which would include the member's nursing home or HCBS waiver patient liability.