How to Navigate Medicaid Pitfalls

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Objectives:

- To have a basic understanding of Medicaid as it relates to individuals on the FSW and CIH Waiver
- To understand how to apply for Medicaid
- To be able to identify and monitor annual redetermination
- To re-establish Medicaid following a lapse
- To know where resources are and how to utilize them
What is Medicaid?

- Enacted in 1965 through amendments to the Social Security Act, Medicaid is a health and long-term care coverage program that is jointly financed by states and the federal government.
- Each state establishes and administers its own Medicaid program and determines the type, amount, duration, and scope of services covered within broad federal guidelines.
- Federal law also requires states to cover certain mandatory eligibility groups, including qualified parents, children, and pregnant women with low income, as well as older adults and people with disabilities with low income.
- In Indiana, eligibility is determined by the Division of Family Resources (DFR).
What is a Medicaid Aid Category?

- A designation under which a person may be eligible for public assistance and medical assistance.

- Medicaid has many aid categories. Examples of these categories are aged, blind, and disabled.
Medicaid Aid Categories

The following Medicaid Aid categories are compatible with the Waiver:

MA-A  Medicaid for the aged
MA-B  Medicaid for the blind
MA-D  Medicaid for the disabled
MA-SI  Medicaid for SSI recipients

MA-DW MED Works: Medicaid for Employees with Disabilities

Plus.....
More Medicaid Aid Categories:

MA-GF  Medicaid for Parent/Caretaker, AFDC income standard
MA-F   Transitional Medical Assistance up to 12 months when the caretaker relative obtains employment
MA-Y   Children under age 19, code varies by age and income limits
MA-Z
MA-2
MA-9
MA-4   Wards of the DCS who are in foster case and receiving federal assistance under Title IV-E Foster Care
MA-8   Under 19 with Adoption Assistance through Department of Child Services
MA-14  Former foster children ages 18-20, up to 210% FPL
MA-15  Former foster children ages 18-25, no income standard
What is HHW?

- Hoosier Healthwise (HHW) is a health care program for low income parents/caretakers and children.
- Covers children up to age 19, pregnant women, and low income parents/caretakers of children under the age of 18.
- Includes Children's Health Insurance Plan (CHIP) for children up to 19. (Low cost monthly premiums for families who earn too much for standard HHW)
HHW and the Waiver

- HHW is managed through Managed Care Entities (MCE) Anthem, MDwise, and Managed Health Services (MHS)
- Managed Care is NOT compatible with waiver
- Waiver participants are automatically disenrolled from MCE’s when waiver budget is confirmed.
- Household income is used to determine eligibility.
What is A/B/D?

- Most common aid categories for waiver participants
- A-Aged—65 or older
- B-Blind
- D-Disabled
- Special Waiver Rules apply to these aid categories—Parental income/resources excluded
- Have same financial eligibility criteria
Special Waiver Rules

- Senate Bill 30-Provision which allows parental income and resources to be disregarded when determining Medicaid eligibility for children under the age of 18 in a Medicaid certified facility or being considered for the Medicaid Waiver program in lieu of institutionalization.

- Special Income Level (SIL)-Specific financial eligibility determination test.

- Special Waiver Rules apply to MA-A, MA-B, and MA-D.
A/B/D Financial Eligibility Criteria

- Income limit without the waiver: 100% FPL or $981/month in 2015
- Income limit with the waiver: 300% maximum SSI benefit or $2199/month for 2015
- Individuals with income* over $2199 need Miller Trust
- Resources/assets must be under $2,000 Single or $3,000 Couple, except for house and 1 vehicle
- Resources include savings, retirement (401K) plans, life insurance with cash surrender value, land, cash on hand, etc.
Hoosier Care Connect

- New Risk Based Managed Care for the Aged, Blind, and Disabled
- Current aid categories that it will include are Aged (65 +), Blind, Disabled, SSI recipients, and MED Works.
- Excluded populations includes Medicare recipients, HCBS Waiver, Money Follows the Person, and institutionalized.
- Enrollment anticipated from February to June 2015
Medicare

- Medicare is a Federal health insurance program for people 65 or older, or for people under 65 with certain disabilities.
- Under 65 if receiving Social Security Disability Insurance (SSDI) for at least 24 months.
- Monthly premium for Medicare is paid through deduction of SSDI benefit check or through Medicaid if eligible.
Medicaid for the Disabled (MA-D) and Social Security Disability (SSD)
1634 Transition

- On 6/1/14, Indiana transitioned from a state determination of eligibility (209b) to a federal determination using Social Security Administration (SSA) standards (1634) for disability.
- Medicaid relies on SSA to determine disability for adults.
Medicaid Eligibility

- If someone receives Social Security Disability benefits (SSI and/or SSDI), then he/she meets the disability criteria for Medicaid for the Disabled.

- Medicaid previously used their Medical Review Team (MRT) to determine disability.

- Medicaid now relies on SSA to determine disability for adults.

- MRT is still used for minors.
Supplemental Security Income (SSI) is a disability payment for low income individuals. Full amount is $733/month in 2015. May be less if individual is working or does not have many expenses.
- Social Security Disability Insurance (SSDI) is a disability payment based on a person’s work history.
- Individuals with a disability can draw on a parent’s work history if the parent is deceased, disabled, or retired.
- Amount is typically higher than SSI.
- May receive both SSI and SSDI
- Eligible for Medicare after receiving SSDI benefits for 24 months.
- Payment for Medicare Premiums is taken out of the SSDI check monthly if not eligible for Medicare Savings Program through Medicaid.
Medicaid and SSI

- If a person receives SSI, he will automatically be eligible for Medicaid for the Disabled.
- The aid category will be MA-SI to reflect that he/she is receiving SSI.
- SSI Recipients do not need to complete annual recertification for Medicaid.
Medicaid and SSDI

- A person with SSDI meets the disability requirement for MA-D, but needs to verify finances through recertification process.
- Since the SSDI amount is often more than SSI, the MA-D recipient will need to verify that his/her income and resources are within the eligibility guidelines with Medicaid to retain benefits.
- Financial: Income under $2199 or Miller Trust, earned income under $1090*, and Resources under $2000 for an individual on the waiver
- SSDI Recipients need to complete annual recertification for Medicaid.
Income over $2199

- If a person has income (likely unearned income) of over $2199/month, the excess income needs to be placed in a Qualified Income Trust (Miller Trust).

- If a person has earned income (wages) and works close to full time, then he is likely on MED Works (MA-DW) which follows a different set of rules than MA-D. Even though total income may be over $2199/month, a Miller Trust would not be required.
**Trusts: Resources**

**Special Needs Trust** will allow the individual to have more than the allowable assets to retain government benefits.

- Two types of Special Needs Trusts: Grantor or Third Party Trust
- Can be set up using a variety of resources including:
  - Bank
  - Lawyer
  - The ARC Master Trust ([www.thearctrust.org](http://www.thearctrust.org))

**Burial Trust** is purchased through the funeral home of choice. Additional funds can be used to purchase or make payments on a recipient’s funeral, burial plot, headstone, and other related expenses.
Achieving a Better Life Experience (ABLE): New law signed 12/2014. ABLE accounts are designed to help people with disabilities save money without risking their eligibility for government benefits.

- Similar to 529 College Savings Plan
- Deposit up to $14,000 a year
- Use the saved money to pay for healthcare, education, and other expenses
- Only people who acquire a disability before age 26 are eligible.

Federal Treasury Department is expected to release regulations by the end of 2015.
Trusts: Income

Qualified Income Trust (Miller Trust) will allow an individual who has more than the allowable income to retain Medicaid benefits.

- Income over $2199/month (amount changes annually) needs to be placed in the trust.
- Can only be used for income; cannot be used for resources
- If a recipient’s income increases or decreases, this will affect the amount that needs to be deposited in the Miller Trust. Individual/auth rep responsible is for determining the amount.
- Individuals may apply certain deductions to these funds and the remaining amount will be used to pay for cost of care.
- Similar to Spend Down, but now referred to HCBS Liability
- Due to the nature of the trust, almost all funds deposited into the trust will be depleted by the end of the month.
- Upon the recipient’s death, any and all funds remaining in the Miller Trust, up to the total cost of care, would be paid to Medicaid.
Miller Trust

- A Miller Trust is a special legal arrangement for holding the excess income.
- If a Miller Trust is needed in order to stay eligible for Medicaid, an attorney can be contacted for advice on how to establish a Miller Trust.
- A Trust Account must be set up with a financial institution to receive the funds directed into it each month.
- Detailed instructions for establishing a Miller Trust can be found at http://www.in.gov/fssa/ddrs/4860.htm
**MA-D recipients prior to 6/1/14:**

- If they have been approved for MA-D by the Medical Review Team (MRT) and the condition has been determined to be "lifelong," then they will still be eligible for MA-D even if they have never applied for SSD.

- If they have been approved for MA-D by the Medical Review Team (MRT) and the condition has been determined to be short term or something that could show improvement and progress reports are required about the condition, then the person will need to apply for SSD at the time that the next progress report is due.
SSD Denials

- If an individual was approved for MA-D prior to 6/1/14, a SSD denial prior to 6/1/14 is disregarded. He/She is not required to apply for SSD unless an MRT progress report is due.

- If an individual was approved for MA-D and receives a SSD denial after 6/1/14, Medicaid will follow the SSD decision. Medicaid remains active for 60 days to allow time for SSD appeal to be filed. If the SSD denial is appealed within 60 days, Medicaid will remain eligible until SSD appeal decision is made.
New MA-D Referrals:

- Any new application (or re-application) made to Medicaid for an adult for Medicaid for the Disabled will need to apply for Social Security Disability benefits (SSI, SSDI).
- Medicaid is allowed 90 days to process a new MA-D application. SSA decision may take greater than 90 days.
- Medicaid will have the MRT review for disability. If eligible, will be given eligibility until SSA makes a decision.
- Once SSA makes a decision, Medicaid will go along with the SSA decision. However, if a SSD denial is appealed in a timely manner (60 days), Medicaid will remain eligible until the SSD appeal decision is made.
MED Works

- Also need to be eligible for SSI or SSDI to show disabled.

- If a recipient of MED Works is determined to no longer be disabled according to SSA, an MRT progress report is required to determine if the Medicaid Member is disabled. Aid category change from MED Works (MA-DW) to MED Works Medically Improved (MA-DI).
Resources Regarding 1634

FSSA has posted detailed information about the changes on their website at:

http://www.in.gov/fssa/ddrs/4859.htm

Includes:

- Copy of notice sent to recipients and authorized representatives about the changes
- Comprehensive Q/A
- Eligibility Screening Guides
- Stakeholder Presentation 1/30/14
- Medicaid Policy Chapter 2412
Avoiding Medicaid Pitfalls
Recertification

- **Eligibility for Medicaid is redetermined annually.**
  - The month typically stays the same from year to year, as long as there is no lapse in services.
  - DFR typically sends out the paperwork for recertification approximately 6 weeks prior.
  - Team members should follow up with individuals, guardians and RHSO provider (if applicable) to ensure individual continues to adhere to guidelines to qualify for Medicaid.
  - Remind them to look for mailing from DFR, submit requested information timely, and ensure resources are below $2000.
  - If recertification paperwork is not received when anticipated, call DFR to inquire.
  - **Redeterminations are temporarily suspended.**
Recertification Requirements

- For A/B/D, only report the waiver participant’s income and resources.
- Attach supporting documents such as paystubs, bank statements, and private insurance card.
- Submit by the due date.
Medicaid Lapse at Recertification

Medicaid typically lapses due to one of these reasons:

- Recertification paperwork was not completed and returned to Medicaid
- All documentation was thought to be turned in but was not complete or not received by Medicaid by the due date.
- Person was over resources when bank statements were submitted.
- A new resource was discovered at the recertification, such as life insurance, that put him/her over resources.
Recertification Common Errors

- Recertification paperwork is only sent to the authorized representative. If the authorized representative information is not current or accurate, the annual recertification paperwork will not be received.

- Change in address not reported to DFR. Recertification paperwork is mailed to the former address and not received.
MED Works

- Medicaid for Employees with Disabilities
- Often requires a monthly premium payment based on income that needs to be paid in order to retain Medicaid benefits
- Participation in the waiver does not change the income limit before a premium is assigned.
- Once an individual earns a certain income level, MED Works is the appropriate aid category.
MED Works: Income

- Once a waiver participant earns more than the Substantial Gainful Activity (SGA) level, he/she is required to be on MED Works. SGA is $1090/month gross earnings in 2015.
- Works with a premium payment.
- Premium payment is based on earned and unearned income using a sliding scale.
- Medicaid Policy #3325.20.00

Pitfalls:
- Individuals with earned income under $1090 per month are being placed on MED Works with a premium payment in error.
- Premium payment is not paid and Medicaid is lost.
MED Works: Resources

- Funds in retirement accounts or Independence & Self Sufficiency Accounts do not count toward the $2000 resource limit under MED Works.

- Pitfall: Individual stops working, no longer qualifies for MED Works, and is over the resource limit for MA-D.
QMB Only

- Qualified Medicare Beneficiary
- Also referred to as Medicare Savings Program
- It is available for low income Medicare beneficiaries.
- Medicaid pays the Medicare premiums, coinsurance, and deductibles.
- May have QMB only or QMB in addition to traditional Medicaid.

- QMB Only is NOT compatible with the waiver.
- QMB Also is compatible with the waiver.
QMB Only – Eligibility Screen

Eligibility Inquiry

Query Information
- Legacy Provider ID
- Service Location
- Search Criteria: By Member ID
- Member ID
- From Date: 01/12/2015
- To Date: 01/12/2015

Eligibility Information
- Member is Eligible from 01/12/2015 to 01/12/2015 for Medicare Coinsurance Deductible Only
- Inquiry completed at 5:34:25 PM on 1/12/2015
- Member Name
- Address
- Date of Birth
- Spendsdown/HCBS Waiver Liability
  - None
- Medicare Part A, B and D
- Medicare Number
- Patient Liability
- $0.00
- Nursing Home Resident
  - WAIVER
- Restricted
  - No
- QMB
  - QMB ONLY
- Other Private Insurance
  - Yes
- Member is restricted to
  - None
Addressing QMB Only

- If QMB Only, the individual will have an MA-aid (MA-L, MA-J) category and believe that they have Medicaid. However, the aid category assigned is not compatible with the waiver and the individual will not be able to receive waiver services.
- If an individual has QMB Only, the authorized rep needs to contact DFR to determine why full Medicaid coverage was lost and what is needed in order to establish full coverage.
- When an individual is assigned QMB Only, it typically means that full Medicaid coverage was lost during the annual recertification due to not submitting required documentation or being over resources.
Documentation

- DFR only confirms receipt of documents if hand delivered to a local office.
- DFR does not inform if documentation received is unclear or incomplete.
- Takes 2-3 days for documents scanned into their system to be visible to the case worker.
- Always call DFR 2-3 days after documentation is submitted to assure received and complete
Documentation Common Errors

- Documentation is submitted on the due date.
  - System looks for the documentation the day following the due date, does not see it, and issues denial. Does not allow for the 2-3 days for it to be visible.
  - If documentation cannot be turned in early, the authorized rep needs to call DFR to assure documentation was received and will be processed.
Documentation Common Errors

- Documentation is submitted after the due date.
  - Likely that a denial has already been issued
  - There is no mechanism to flag documentation to be reviewed and processed when turned in late.
  - Need to call DFR to assure received, complete, and to request that it be processed.
Documentation Common Errors

- Submitted documentation was incomplete
  - If all of the documentation requested is not received, DFR does not inform of what is missing. It is automatically denied.
  - Bank statements need to show full name of account holder, full account number, and name of the bank. Screen shots from the internet typically are not accepted.
  - A faxed page did not come through or was blurry.
Documentation Common Errors

- Documentation was submitted, but not visible
  - Use Bar Coded Cover sheet.
  - If Bar Coded Cover Sheet is not available, write full name, DOB, SSN, and Case Number on your own cover sheet as well as documents.
  - Check for multiple case numbers.
Documentation

- To avoid any concerns with documentation, the authorized rep should call DFR 2-3 days after documentation was submitted to assure that it was received, complete, and will be processed.

- If the Medicaid was denied due to not turning in documentation, and denial was not related to eligibility, DFR should accept and process requested documentation for 90 days without a new application being required.
Inability to Talk with DFR

An authorized representative form can be completed allowing a particular person to act on the individual’s behalf.

- Need authorized representative form or legal guardianship paperwork on file for a parent to talk with DFR regarding adult child.
- Authorized rep form can be obtained at http://www.in.gov/fssa/dfr/2689.htm
- Up to 4 authorized reps are allowed.
- Authorized Rep forms are valid per application. Likely need to submit a new form if new Medicaid application is filed.
“Waiting to Hear Back”

- Often a family or authorized rep says that information was submitted and they are waiting to hear back from Medicaid.
- Do not assume that information submitted is being processed or that the case is still being worked.
- Need to call every 7-10 days to check on the status.
- Case workers typically do not leave voice mail.
Change in SSD Benefits

- If SSI benefits change to SSDI, need to show that financial eligibility is met.
  - Information should be shared electronically between SSA and DFR to signal category change from MA-SI to MA-D.

- Pitfall: Individual loses Medicaid eligibility month that SSI stops.
  - Need to report SSD benefit change to DFR and submit supporting financial documentation.
Prior Quarter Coverage

- Once eligibility is determined, the start date will typically be retroactive through the previous three months.
- Prior coverage may be greater than three months if there was an appeal, delay of processing, etc.
- In order to receive Medicaid coverage for the prior quarter, the applicant needs to meet eligibility criteria and submit supporting documentation for that time frame.
- If the applicant incurred any medical expenses during this timeframe, he would want to request that medical professionals resubmit claims to Medicaid.
- Pitfalls:
  - Did not submit supporting documents for each month coverage is being sought
  - Signed Voluntary Withdrawal for prior quarter coverage
Tips for Retaining Medicaid

Call 1-800-403-0864, visit local DFR office, or access DFR portal online to report changes.

Report all changes, such as:
- new address
- new phone number
- change in income
- new job
- resources (inheritance, lottery, etc.)
- authorized rep
Resources
Medicaid Resources

http://www.in.gov/fssa/2407.htm#

Provides access to:

- DFR Portal (www.ifcem.com)
- DFR Region Map and locations of all county offices
- Provider locator by specialty and/or location
- Forms
DFR Region Email

Region emails should be used for:

- Non-routine submission of information
- Reporting spend down if an individual has been assigned one in error
- Action should have been taken by DFR on behalf of an individual and has not been completed

If the team member is not the authorized rep, DFR will reply letting her know that issue is being addressed. However, DFR will only provide follow up information to the authorized rep.

http://in.gov/fssa/files/DFR_Map_and_County_List.pdf
Medicaid Resources

Medicaid Program Policy Manual:
http://in.gov/fssa/ompp/4904.htm
- Eligibility Criteria for each aid category
- Chapter regarding Medicaid Waiver
- Defines income and resources
Medicaid Resources

http://www.indianamedicaid.com

- Resource for providers and members
- Family friendly descriptions of programs and benefits
- Resource center
- Links to apply, find providers, and seek assistance
- Indiana Health Care Plans provider manual
Handy Phone Numbers

1-800-403-0864: Establish eligibility for Medicaid
- Option 1: Health Insurance/Medicaid
- Then select Option 2 again for Case Status Player OR
- Option 8 to talk with a case worker

1-800-457-4584: Member Services - Used to ask specific questions about Medicaid health coverage

1-855-577-6317: Catamaran - Used to ask specific questions about pharmacy services/coverage

1-800-269-5720: Advantage - Oversees Medicaid PA

1-800-433-0746: Help Line - Provides assistance with locating Medicaid accepting doctors and other providers.
Questions

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