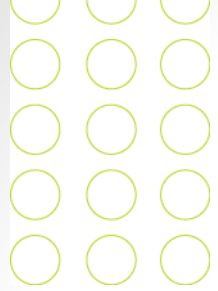# Medicaid Eligibility: Understanding the Essential Concepts
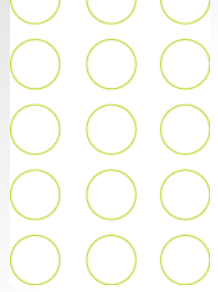
Presented by Diane Buff

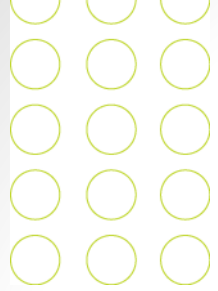IPMG Medicaid and Intake Support Manager

January 20, 2017

Objectives:

- To have a basic understanding of Medicaid as it relates to individuals on the waiver

- To understand how to apply for Medicaid

- To be able to identify and monitor annual redetermination

- To reestablish Medicaid following a lapse

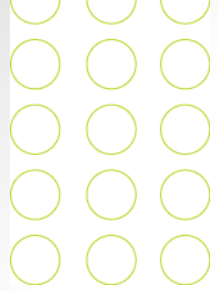- To know where resources are and how to utilize them

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Essential Terminology

o Medicaid

o Medicaid Waiver

o Division of Family Resources

o Medicaid Aid Category

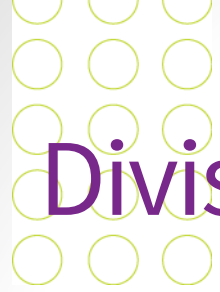o Traditional Medicaid

o Authorized Representative

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Medicaid

o Public health insurance program for persons of all ages whose finances and resources meet specific guidelines.

o Jointly funded by the state and federal government

o Eligibility standards vary by state.

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Medicaid Waiver
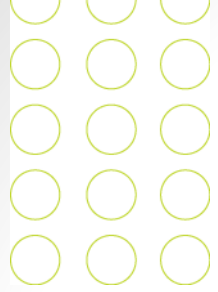
- Provides needed disability related services in the home and the community.
- "Waives" the requirement for services to be provided in an institution such as a group home or nursing home.
- Family Support Waiver (FSW)
- Community Integration and Habilitation Waiver (CIH)
- Aged & Disabled (A&D)
- Traumatic Brain Injury (TBI)
- Must have Medicaid in order to use waiver services

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Division of Family Resources (DFR)

o State agency under FSSA

o Responsible for establishing eligibility for Medicaid

o Processes Medicaid applications

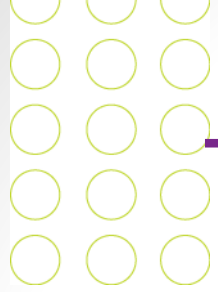o Determines continued eligibility

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Medicaid Aid Category

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

o "Eligibility Path" to Medicaid

o Medicaid has many aid categories. Examples of these categories are aged, blind, and disabled.

o It is important to know the aid category as it determines the eligibility requirements

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Medicaid Aid Category (cont'd)

o Not all types of Medicaid are compatible with the waiver

o The most common aid categories for Individuals on the Waiver are:

   o Medicaid for the Aged (MA-A)

   o Medicaid for the Blind (MA-B)

   o Medicaid for the Disabled (MA-D)

   o Medworks (MA-DW)

   o Medicaid for SSI Recipients (MA-SI)

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Traditional Medicaid

o The majority of Medicaid recipients are enrolled with a managed care entity such as MDWise, MHS, Care Source IN, or Anthem.

o Individuals on the waiver do not participate in managed care.

o When a Medicaid recipient is not enrolled with a managed care entity, they are considered to have Traditional Medicaid.
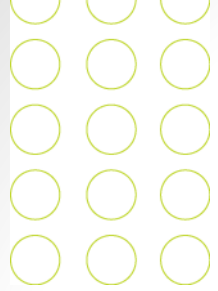
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Authorized Representative

o Allows another person or agency to advocate or represent the Medicaid recipient when communicating with DFR.

o May be a family member, provider, or friend

o In order for the DFR Caseworker to talk with someone other than the Medicaid recipient, authorized rep form needs to be completed and submitted to DFR.

o Authorized reps receive copies of most DFR notices to the Medicaid recipient

o Parent of a minor child or guardian does not need an authorized rep form.

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Essential Concepts for Eligibility

o Income

o Resources

o Aged or Disabled

o Working while Disabled

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Income

o Income is the money that is received.

o Income can be earned or unearned.

o For the majority of aid categories, household income is considered and must be below a certain % of the federal poverty level.

o DFR may require that proof of income such as paystubs be submitted during the eligibility process.
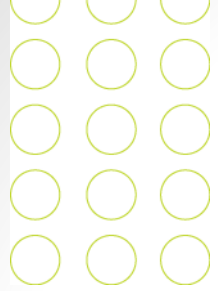
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Income: Special Waiver Rules

o If a person is approved for the waiver and household income would prevent them from being approved for Medicaid, a Special Waiver Rule allows parental or spousal income not to be counted when determining eligibility for Medicaid for the Aged, Blind, or Disabled categories.

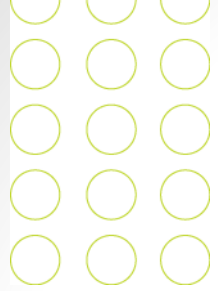o Only the income of the waiver participant are collected and counted.

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Income limit for Aged/Disabled

o Income limit for MA-A,MA-D for a Waiver Participant is $2205/month (3 x current SSI)

o Up to $1170/month can come from earned income

o If total income is over $2205/month, a Miller Trust is needed. The excess income goes into the trust and is used to pay for Medicaid services and is called a Waiver Liability (spenddown).
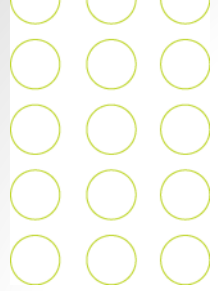
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Resource

o Resource is defined as real or personal property that is owned solely or jointly by a Medicaid recipient

o Includes cash, checking, savings, bonds, stocks, and cash surrender value of a life insurance policy owned by the Medicaid recipient.

o Home the person lives in and one car are typically excluded

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Resource Limits

o The majority of Medicaid aid categories do not factor in resources

o Resources are collected and counted for Medicaid for Aged, Blind, and Disabled categories.

o The resource limit is $2000. This is a total of all resources in the person's name as of the first of the month.

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Resources: Exempt

The following resources are not typically counted toward the $2000 resource limit:

o The primary home

o Personal effects and household goods

o One motor vehicle

o Burial spaces and irrevocable prepaid burial trust

o Resources in irrevocable Special Needs Trust or ABLE Account

o

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Spousal Impoverishment Protection Law: Resources

o Applies to Aged and Disabled Waiver.

o Resources of a married couple are generally considered to be jointly-owned no matter in whose name they have been placed.

o The non-waiver spouse is allowed to keep at least one-half of the total non-exempt resources.

o The waiver spouse cannot have more than $2000 in resources.
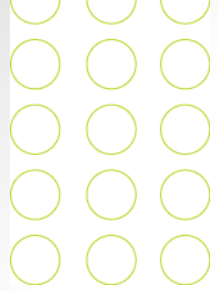
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Spousal Impoverishment Protection Law: Resources (cont'd)

o When first applying for Medicaid, a snapshot is taken of the resources.

o If resources are under $24,180, the non-waiver spouse can keep all of the assets.

o If resources are greater than that, the waiver participant's portion of the resources need to be spent.

o The waiver participant is allowed only $2000 in available (non-exempt) resources to be eligible for Medicaid.

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Other Eligibility Factors

o Medicaid for the Aged: Person needs to be at least 65 years of age

o Medicaid for the Disabled: Determined disabled by SSA or meet the SSA definition of disabled as determined by Medicaid Medical Review Team (MRT)

  o Under 18: Physical or mental condition(s) that result in marked and severe functional limitations

  o 18+: Unable to engage in substantial gainful activity because of a medically determinable physical or mental impairment
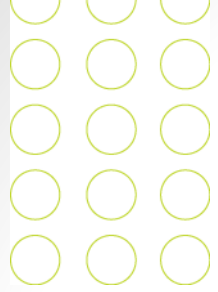
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MED Works

o Medicaid for the Disabled and Working

o Required to be on MEDWorks rather than MA-D if:
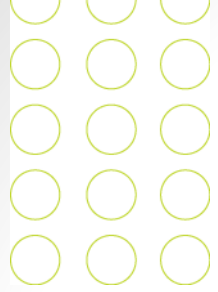
   o Income from work is over $1170/month gross

OR

   o Resources in 401k or IRA would put them over the $2000 resource limit

o Monthly premium required based on sliding scale of total income (earned and unearned)
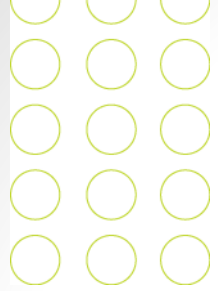
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Medicaid for the Disabled (MA-D) and Social Security Disability (SSD)

SSI

o Supplemental Security Income (SSI) is a disability payment for low income individuals.

o Full amount is $735/month in 2017.

o May be less if individual is working or does not have many expenses.
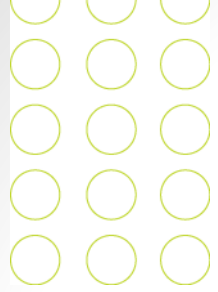
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SSDI

o Social Security Disability Insurance (SSDI) is a disability payment based on a person's work history.

o Individuals with a disability can draw on a parent's work history if the parent is deceased, disabled, or retired.

o Amount is typically higher than SSI.

o May receive both SSI and SSDI.

o Eligible for Medicare after receiving SSDI benefits for 24 months.
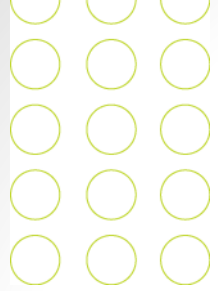
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Medicaid Eligibility

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

o If a minor does not meet the financial eligibility for SSI due to parental income, then DFR uses their Medical Review Team to determine if the person meets the disability criteria for MA-D.

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Medicaid and SSI

o If a person receives SSI, he will automatically be eligible for Medicaid.

o The aid category will be MA-SI to reflect that he/she is receiving SSI.

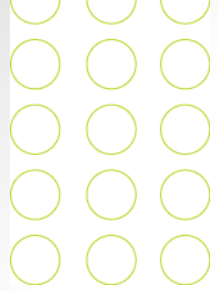o SSI Recipients do not need to complete annual recertification for Medicaid.

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Medicaid and SSDI

o A person with SSDI meets the disability requirement for MA-D, but needs to verify finances.

o 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.

o Financial: Income under $2205 or Miller Trust, earned income under $1170*, and Resources under $2000 for an individual on the waiver

o SSDI Recipients need to complete annual recertification for Medicaid.

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MA-D Recipients before 6/1/14

o 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.

o 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.

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SSD Denials

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

o If an individual was approved for MA-D and SSA makes a new determination that the person is not disabled, 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.
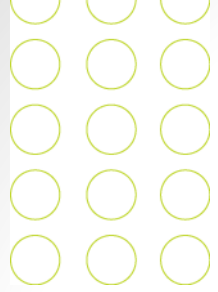
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New MA-D Referrals

o Any new application (or re-application) made to DFR for Medicaid for the Disabled will need to apply for Social Security Disability benefits (SSI, SSDI)

o Medicaid is allowed 90 days to process a new MA-D application. SSA decision may take greater than 90 days.

o Medicaid will have the MRT review for disability. If eligible, will be given eligibility until SSA makes a decision.

o 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.

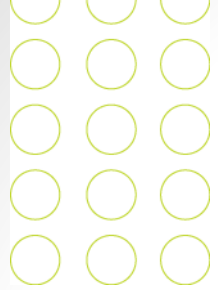ipmg

Essential Components of Medicaid Application and Renewal

o Application

o Recertification

o Auto Renewal

o Medicaid Lapse at Recertification

o Common Documentation Errors

o Tips for Retaining Medicaid
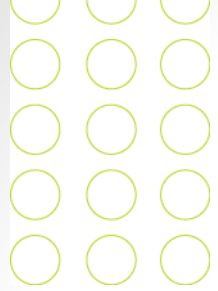
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Applying for Medicaid

o Submit a Medicaid application on line at www.ifcem.com, at a local DFR office, or by calling DFR

o Takes about 45-90 days to determine eligibility

o Interview is completed with DFR Case worker in person or over the phone

o Typically given 13 days from the date of the interview to turn in supporting documentation.

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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.
- Team members should follow up with individuals, guardians and residential provider (if applicable) to insure 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.
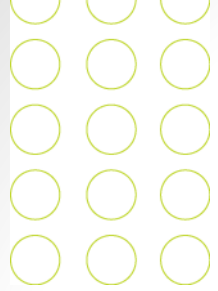- If recertification paperwork is not received when anticipated, call DFR to inquire.

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Medicaid Mailer

o The recertification form is called the Medicaid Mailer

o The Medicaid Mailer is preprinted providing the financial information that was last reported and sent about 6 weeks before the recertification date.

o The cover letter indicates that the form does not need to be returned if nothing has changed. This can be misleading.

o For MA-A, MA-B, MA-D, proof of current resources need to be attached and the form signed.

o If the person has income other than SSD, paystubs or other proof of income needs to attached and the form signed.

o If the Medicaid Mailer is received, it should be reviewed, changes noted, signed and returned with supporting documents

Recertification Requirements

o For A/B/D, only report the waiver participant's income and resources.

o Attach supporting documents such as paystubs and bank statements

o Assure all documents received by DFR by the due date
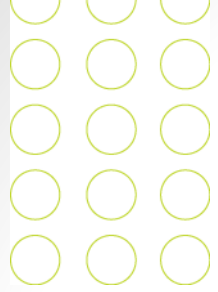
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Auto Renewals

o If the Medicaid Member receives SSI, Medicaid is automatically eligible as long as they receive SSI payments

o If there is no income other than SSD and the waiver participant has no resources in his name, DFR may automatically determine the person eligible for Medicaid at renewal time.

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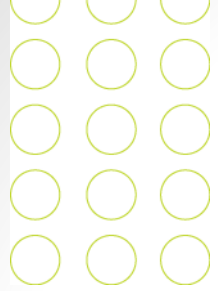# Medicaid Lapse at Recertification

Medicaid typically lapses due to one of these reasons:

o Medicaid Mailer was not completed and returned to DFR

o All documentation was thought to be turned in but was not complete or not received by DFR by the due date.

o Person was over resources when bank statements were submitted.

o A new resource was discovered at the recertification, such as life insurance, that put him/her over resources.

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Documentation

o DFR only confirms receipt of documents if hand delivered to a local office.

o DFR does not inform if documentation received is unclear or incomplete.

o Always call DFR 1-2 days after documentation is submitted to assure received, complete, and will be processed

o Use bar coded cover sheet

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Documentation

o To avoid any concerns with documentation, the authorized rep should call DFR 1-2 days after documentation was submitted to assure that it was received, complete, and will be processed.

o If the Medicaid was denied at recertification 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.
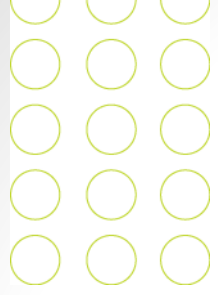
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Tips for Retaining Medicaid

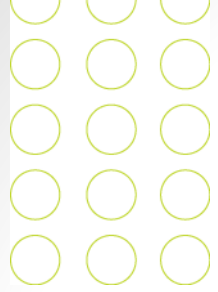**Call 1-800-403-0864,** visit local DFR office, or access DFR portal online to report changes.

Report all changes, such as:
- new address
- new phone number
- Income, including change in SSD benefits
- new job, loss of job
- resources (inheritance, lottery, etc.)
- authorized rep

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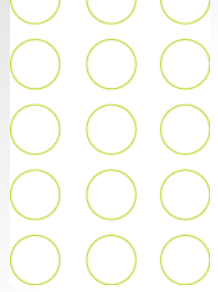ipmg

Resources

Medicaid Resources

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

Provides access to:

o DFR Portal (www.ifcem.com)

o DFR Region Map and locations of all county offices
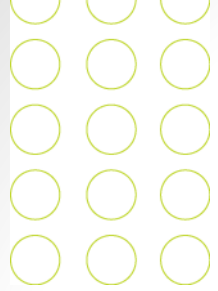
o Provider locator by specialty and/or location

o Forms

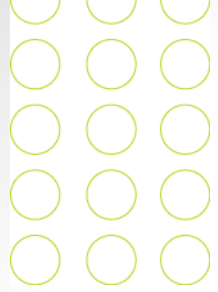**ipmg**

Medicaid Resources

Medicaid Program Policy Manual:

http://in.gov/fssa/ompp/4904.htm

o Eligibility Criteria for each aid category

o Chapter regarding Medicaid Waiver

o Defines income and resources

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Medicaid Resources

http://www.indianamedicaid.com

o Resource for providers and members

o Family friendly descriptions of programs and benefits

o Resource center

o Links to apply, find providers, and seek assistance

o Indiana Health Care Plans provider manual

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Handy Phone Numbers

1-800-403-0864: **DFR**

o Option 1: Health Insurance/Medicaid, then select

o Option 2 again for Case Status OR

o Option 9 to talk with a case worker

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

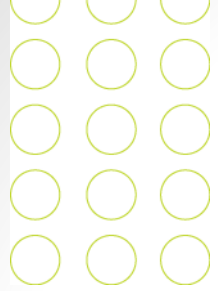1-855-577-6317: **OptumRX** - Used to ask specific questions about pharmacy services/coverage

1-800-269-5720: **Cooperative Managed Care Systems (CMCS)**- Oversees Medicaid Prior Approval

Additional Phone Numbers

- 1-866-273-5897—**MEDWorks** Premium Hotline- make payments over the phone

- 1-800-577-1278—**Provider Relations**— Oversees Medicaid claims, assists with billing issues

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

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Questions

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1/24/2017