

Follow up questions and answers from 2014 ABD Medicaid Eligibility Changes stakeholder briefing

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General Questions

- 1) For disability eligibility, what is the standard requirement if members or applicants have multiple dependents? Is this based on the income and household size for 100 percent of the Federal Poverty Level (FPL)?**

For disability eligibility, household size will be based on Supplemental Security Income methodology. The members may have income of up to 100 percent of FPL for single (household of 1) or married (household of 2) with an additional maximum allocation of \$361 per month for each qualified dependent or essential person. This methodology is displayed on the eligibility charts available on the 2014 Medicaid Disability Eligibility Changes section of the www.in.gov/fssa website.

- 2) After June 1, will the special income limit be 100 percent of Supplemental Security Income (SSI) or 100 percent of the Federal Poverty Level (FPL)?**

The Special Income Limit will be used to determine Medicaid eligibility for disabled institutionalized and waiver populations. The Special Income Limit is already used today to determine eligibility for certain HCBS waiver programs and is 300% of the SSI maximum benefit rate (\$2,163 per month in 2014.) This is different from the Federal Poverty Level (FPL).

3) At what income level will individuals qualify for benefits after the 1634 Transition?

Qualifying income after the 1634 transition depends on whether or not the member is eligible for Medicaid only or is dually eligible for Medicare and Medicaid, is in an institution, is eligible for a waiver or is a member with serious mental illness who is currently accessing Medical Rehabilitation Option (MRO) services.

- Full Medicaid benefits for the aged, blind and disabled will extend to 100 percent FPL (\$11,670 for an individual in 2014) provided asset limits and other eligibility criteria are met.
- The Medicare Savings Program will now extend to incomes of up to 185 percent FPL (\$21,590 for an individual in 2014) provided that members meet the asset limits. Currently, Medicare Savings Program eligibility extends to 135 percent FPL.
- Individuals in institutions or on waivers with incomes below the special income limit of \$2,163 per month will remain Medicaid eligible and will not need to take action. However, those individuals in institutions or on waivers with incomes over \$2,163 per month will need to establish a Miller trust to maintain eligibility.
- Members with serious mental illness that currently access MRO services may be eligible for services through the new 1915(i) Behavioral and Primary Healthcare Coordination program if they have incomes up to 300 percent of FPL.

4) With spend down being eliminated will patients have premiums?

The impact on the elimination of spend down on members depends on the member's income and Medicare status. With the exception of MED Works program participants, Medicaid members will not pay premiums; however, individuals transitioning off of the spend down program to a non-Medicaid option may be responsible for premium payments.

5) With spend down eliminated how will income be proportioned to medical expenses?

For members living in the community, medical expenses will no longer be considered in regard to excess income as the spend down provision is eliminated effective June 1, 2014.

Members in institutions and on waivers with incomes over the special income limit (\$2,163 per month) will need to establish a Miller trust to maintain eligibility. A Miller trust works much like spend down. Medical expenses will be allowable post-eligibility deductions from the Miller trust. There is no change in the post-eligibility budgeting procedures used to determine the amount of the member's liability. Members will deposit excess income into the trust and use this excess income to pay their liability.

6) What are the plans/actions in process to supplement gaps in resources affected by the changes? Examples: loss of non-emergency transportation, additional funding for legal resources for low income members needing a Miller trust and SHIP workers?

There will be some changes in services for members transitioning off of spend down. The main difference in benefit coverage is that non-emergency transportation is not a covered service in federal Marketplace or Medicare products. State analysis of data for the group transitioning off of spend down shows that spend down members also eligible for Medicare typically only meet their spend down and become eligible for Medicaid services one or two months out of the year. For members transitioning to Marketplace coverage, expenditures on non-emergency transportation in State Fiscal Year 2013 totaled just over \$650,000. This amount represents less than 1 percent of the total amount of spend down claims for this population. Members with federal Marketplace coverage will need to pay for this non-covered service separately, but will no longer be required to meet a monthly spend down to access comprehensive coverage. Even when accounting for out-of-pocket expenditures for non-emergency transportation, in general, the Marketplace will offer continuous comprehensive coverage and will be less expensive than current spend down coverage.

For members who must establish a Miller trust to remain eligible for Medicaid, a State-approved trust document template and instructions have been provided, as well as referrals to possible sources of free or reduced-cost legal services. This list of resources can be found under the How to Establish a Miller Trust section of the 2014 Medicaid Disability Eligibility Changes link on the www.in.gov/fssa website. Indiana Medicaid will work with the State Health Insurance Assistance Program (SHIP), the Certified Indiana Navigators, and with the federal Marketplace to ensure that all parties are aware of and ready to help members transition to other coverage options. Enrollment assistance from SHIP and the majority of Certified Indiana Navigators is available to prospective enrollees free of charge.

Assets and Resources

1) Will assets requirements change? How much is allowed in checking and savings?

To align with the Supplemental Security Income asset requirements, beginning June 1, 2014, individuals will have an asset limit of \$2,000 and married couples will have an asset limit of \$3,000. The spousal impoverishment provisions do not change for those couples in which one spouse is institutionalized and the other lives in the community.

2) Will nursing home residents be able to have up to \$1,500 w/o it being in a Miller Trust?

After the transition, nursing home residents will be able to have \$2,000 in assets. The Miller Trust holds only excess income, not assets. Therefore, individuals must continue to meet the asset requirements.

3) When the elderly are going into a nursing home and need to apply for Medicaid will there still be asset limits? Will they transfer savings into a Miller Trust and then be immediately eligible?

There are still asset limits for individuals seeking to qualify for Medicaid on the basis of being aged, blind or disabled. Individuals may have assets of \$2,000 and couples may have assets of \$3,000. Spousal impoverishment provisions for couples that have a community spouse and an institutionalized spouse will still apply. As stated above, the Miller Trust instrument may only be established for excess income, and cannot be used to hold assets or other resources.

The Aged (over 65)

1) Must a person age 65 or older applying for Medicaid go through the disability determination process?

Individuals age 65 or older meet the categorical requirements for Medicaid for the Aged and do not need to have a disability determination made by the Social Security Administration or the Indiana Medical Review Team. These members may continue to file a standard application for Medicaid as they do today. The applicant may be required to apply for Social Security benefits as part of the application process if they are eligible but not currently receiving such benefits.

2) Will individuals age 65 or older be required to do anything to continue to be Medicaid eligible?

Individuals that are eligible for Medicaid on the basis of age will not need to seek a Social Security Disability determination. Members will need to continue to meet all eligibility criteria including the income and asset guidelines to maintain Medicaid eligibility.

3) If a person over 65 loses Medicaid, can the supplemental Medicare policy be purchased without regard to preexisting conditions?

There are two types of supplemental Medicare policies available for Medicare eligible individuals: Medicare Advantage, also known as Medicare Part C, and Medicare supplement or Medigap coverage. Both types of supplemental coverage will help individuals limit their out of pocket expenses and may provide additional benefits beyond what is covered by Medicare.

- Medicare Advantage/Medicare Part C coverage replaces traditional Medicare Part A and B coverage and limits total member out of pocket maximum expenses. Loss of Medicaid is listed as an event that qualifies individuals for a special enrollment period for Medicare Advantage, and preexisting conditions will not be considered. Note: Due to federal rules, individuals with end stage renal disease are not eligible for enrollment into Medicare Advantage.
- Medigap coverage is available without consideration of preexisting conditions to individuals age 65 or older, provided they enroll during an open or special enrollment period. Loss of certain types of supplemental coverage will grant a special enrollment period and FSSA is

working with CMS to clarify that losing spend down Medicaid due to the 1634 transition will qualify individuals over 65 for a special Medigap enrollment period.

For free and unbiased counseling about these options, FSSA is encouraging members who are losing spend down but do not qualify for a Medicare Savings program to call the State Health Insurance Assistance Program (SHIP) at 1-800-452-4800 (TTY: 1-866-846-0139).

Communications to Members

1) Will spend down individuals be notified by mail of their full Medicaid?

All members that are expected to experience changes will be notified. This includes current members that currently have spend down and will gain full Medicaid.

2) Will individuals with Social Security Disability Insurance (SSDI) that are not currently enrolled in Medicaid be notified of the program changes? What do they need to do to get enrolled?

Hoosiers that currently have SSDI but are not enrolled in Medicaid will not receive notification. These individuals are welcome to apply for Medicaid. Upon application, their income and assets will be evaluated for potential eligibility, and they will be determined eligible if their income is less than 100 percent of the Federal Poverty Level (\$11,670 annually for an individual) and they have assets that do not exceed \$2,000 for an individual and \$3,000 for a family. Medicare Individuals with income and/or assets above this limit may be eligible for the Medicare Savings Program.

3) Will the authorized representative for members receive the same communication that the member receives?

Members' authorized representatives will receive the same notices as the members. Members may have a maximum of three authorized representatives that receive notices.

MED Works

1) Will Medicaid continue for MED Works enrollees, or will they be referred to the Marketplace?

There are no direct changes to the MED Works program as a result of the 1634 transition and current MED Works members will not be referred to the Marketplace.

2) Can you provide more detail on how individuals currently in MED Works will have their income and Medicaid eligibility handled?

There will be no changes to the MED Works eligibility criteria or process or to how income is considered for the MED Works program. The only change in eligibility is that as with other members, MED Works members who are required to complete a progress report will need to have a pending application or approved disability status with the Social Security Administration (SSA). MED Works applicants seeking eligibility on the basis of improved disability will not be required to have pending or approved disability application with SSA but will be assessed by Indiana's Medical Review Team.

Social Security Administration Questions

1) What applicants will be referred to the Social Security Administration (SSA) for a disability determination?

In general, all applicants seeking Medicaid eligibility on the basis of disability that have not received a disability determination from the Social Security Administration will be required to file an application with SSA as part of their Medicaid eligibility process. However, disabled children that are assessed by Medicaid as not eligible for Social Security benefits due to lack of work history and groups such as the Amish that have a religious objection to receiving federal benefits will not be required to apply to SSA as part of their Medicaid eligibility process.

2) Could you clarify the procedure for current Social Security recipients who want Medicaid benefits?

Individuals currently receiving disability benefits from the Social Security Administration (SSA) will vary based on if the individual is age 65 or older, is receiving Supplemental Security Income (SSI), or is receiving Social Security Disability Insurance (SSDI).

- Individuals age 65 or older not receiving SSI benefits and individuals receiving SSDI benefits will experience no change in application procedure as a result of this change, and will continue to apply to Medicaid and have their income, assets and other eligibility criteria evaluated as they do today.
- Individuals receiving SSI will be automatically eligible and automatically enrolled in Medicaid if they are not already enrolled.

3) If someone has their own health coverage and is declared disabled by SSA, do they still have to apply for Medicaid?

Unless an individual receives SSI from the Social Security Administration, they will still need to apply to Medicaid to be considered for eligibility. Individuals eligible for SSI will be automatically enrolled in Medicaid. Medicaid is a voluntary program, so individuals that have their own coverage are not required to apply to Medicaid.

- 4) Since the Social Security Administration’s disability determinations can take up to 2 years, does an applicant have to apply through Medicaid in order to establish proof of retro coverage so that once the Social Security application is approved the coverage will cover past Medical bills?**

Applicants applying on the basis of disability are not required to have a final disability determination with the Social Security Administration (SSA) to become eligible for Indiana Medicaid. Applicants that do not have a disability determination or a pending application with SSA will be required to apply to SSA as part of the Medicaid eligibility process. These applicants will need to provide proof of application to SSA to complete their Medicaid application. Indiana will still process disability applications within 90 days and, if there is no decision from the Social Security Administration during this time, then the State’s Medical Review Team (MRT) will determine disability. Regardless of the MRT decision, when the Social Security Administration issues its determination, it will be binding on the state. Therefore, individuals that are found disabled by Indiana’s Medical Review Team but subsequently receive a disability denial from the Social Security Administration would lose their eligibility for Medicaid based on disability.

- 5) Will Medicare disability still remain at two years and a day as it is now?**

Yes. Transitioning to 1634 does not impact how long an individual must have a disability determination to be eligible for Medicare. This is a federal requirement.

Medicare and the Medicare Savings Program

- 1) Is the Medicare Part B premium payment lost when spend down is lost?**

The Medicare Part B premium is still paid for all individuals dually eligible for Medicare and Medicaid with income up to and including 185 percent FPL.

- Dually eligible individuals with income up to and including 100 percent FPL will receive full Medicaid and payment of their Medicare Part B premiums.
- Dually eligible individuals with income between 100 percent and 150 percent FPL will receive coverage through a Medicare Savings Program that provides payment for their Medicare Part B premiums and Medicare cost sharing.
- Those dually eligible individuals with income between 150 percent FPL up to and including 185 percent FPL will receive payment for their Medicare Part B premiums through the Medicare Savings Program. Note: Federal authorization for the Medicare Savings Program that is proposed to pay Medicare Part B premiums for individuals with income between 170 percent and 185 percent FPL expires March 31, 2014 and will need reauthorization prior to June 1, 2014 to ensure that Medicaid can make these premium payments on behalf of these individuals.
- Medicare eligible individuals on spend down Medicaid with income over 185 percent FPL will not be eligible for the Medicare Savings Program and the Medicaid program will no longer cover payments of the Medicare Part B premium.

- Medicare eligible Individuals that qualify for the 1915(i) BPHC program for individuals with serious mental illness, or who receive waiver or institutional services, are eligible for full Medicaid, including payment of the Medicare Part B premium.

2) Is the process changing for applying for the Qualified Medicare Beneficiary (QMB) portion of the Medicare Savings Program? Is QMB an automatic for dual eligible? What is the income guideline for QMB?

There will be no process change for those applying for QMB, or any other Medicare Savings Program categories. Eligibility for the QMB category of the Medicare Savings Program will extend to 150 percent FPL. Individuals that are currently enrolled and would be eligible for any of the Medicare Savings Program categories will be automatically transitioned. Individuals that are not currently enrolled will need to apply for Medicare Savings Program eligibility.

3) Will Medicare savings have access to Medical Rehabilitation Option (MRO) services? How?

Individuals enrolled in the Medicare Savings Program are only eligible for services covered by Medicare. MRO is not a covered Medicare Service. However, the 1915(i) BPHC program was created to ensure that individuals with serious mental illness that need MRO services are able to continue to access these services. More information on the benefits and application process for this program can be found in the [Behavioral and Primary Healthcare Coordination program](#) section of the FSSA website.

Miller Trust

1) If a nursing home resident has income over the allowable level, will their medical bills and nursing home room and board be subtracted from their income before benefits are denied?

No. Medicaid eligibility for nursing home residents consists of a two-step process for income purposes. The first step is to determine eligibility under a special income level (SIL), which is 300 percent of the SSI amount or \$2,163 per month for 2014. Amounts of income that are placed into a Miller Trust are deducted for determining eligibility under the SIL. The second step determines the person's liability payment he or she is responsible for paying to the facility before Medicaid. This second step may take medical bills that are not payable by any other third party into consideration to determine the person's liability. The second step will also consider the portion of the person's income that gets placed into the Miller Trust that was exempted for determining eligibility under the SIL.

2) Can a nursing home resident who has income over the allowable limit simply direct the excess income to the Miller trust and thus become eligible (if all other criteria are met)?

Yes. The purpose of a Miller trust is to allow individuals with income over the allowable income limit for institutional or waiver services, but who meet all other Medicaid eligibility requirements, to qualify for Medicaid. Income placed in a Miller trust is used to pay providers.

3) Should members who need to establish a Miller Trust consult an attorney?

Yes. Because a Miller Trust is a legal document that could affect an individual's Medicaid eligibility, the State encourages members to consult an attorney. The instructions on how to set up a Miller Trust on FSSA's website contain contact information for potential sources of free or low-cost legal assistance.

4) For the population that needs a Miller trust June 1, can the attorney fees to establish the trust be paid from what is deposited into the trust after it is established?

The State's post-eligibility budgeting rules do not include attorney fees as allowable deductions.

5) Will we be notified of those eligible for a Miller trust?

Members that need to establish a Miller trust will be notified. Members' authorized representatives will also receive the notification.

6) When elderly individuals are going into a nursing home and need to apply for Medicaid will there still be asset limits? Can they transfer savings into a Miller trust and then be immediately eligible?

There are still asset limits for individuals seeking to qualify for Medicaid on the basis of being aged, blind, or disabled (\$2,000 for an individual and \$3,000 for a couple). The spousal impoverishment provisions apply for a couple that has an institutionalized spouse and a community spouse. The Miller trust instrument cannot be used for assets and can only hold excess income. There is no transfer penalty for putting income into a Miller trust.

The Federal Marketplace and Marketplace Coverage

1) By "federal Marketplace," do you mean the general insurance or specifically the ACA Market?

The term federal Marketplace refers to the ACA market or Exchange that can be accessed at <http://www.healthcare.gov>. For individuals that want to access subsidies this is the only source of coverage available.

2) When dealing with the Marketplace, they seem to be telling people that they qualify for Medicaid when they do not and are over the income guidelines. What is being done to address this?

Members transitioning off of spend down will have already been determined not eligible for Medicaid by the Agency. This should help prevent the Marketplace from assessing them to be potentially Medicaid eligible.

3) Do you see a smooth transition between spend down and the Marketplace?

FSSA continues efforts to assure the smoothest possible transition for all members.

4) Our local hospital is refusing some plans in the Marketplace. Is this being addressed at the local level so people know not to choose those plans?

All qualified health plans offered on the federal Marketplace are certified by the federal Center for Consumer Information and Insurance Oversight (CCIIO) as meeting network adequacy and essential community provider standards. When individuals seek coverage in the Marketplace either by themselves or through a Navigator, they can use the Marketplace website to request more information about the providers that are in a plan's network. The State is including in its member communications information about how to find a Navigator to assist with the transition to the Marketplace. Individuals may also call the health plans directly to find out what providers are in their network.

Navigators

1) Will Navigators have updated training?

FSSA is coordinating efforts with the Indiana Department of Insurance (IDOI) to ensure that all certified Indiana Navigators receive updated information about the 2014 Medicaid Disability Eligibility changes and the 1915(i) BPHC program.

Authorized Representatives

1) How will the 2014 changes impact authorized representatives?

The Medicaid Disability Eligibility changes will have no direct impact on authorized representatives. It is encouraged for spouses who wish to act in the capacity of an authorized representative complete the authorized representative form to ensure they receive eligibility notices.

2) Will members only be allowed one authorized representative?

Members may have up to three authorized representatives.

3) Will the changes impact the Agency Portal?

The Agency Portal will be updated with the 1634 transition information and new eligibility criteria. There will not be changes to how authorized representatives or other qualified parties interact with the Agency Portal.

4) Will members be required to complete authorized rep forms for FSSA and SSA?

Yes, members that want to designate authorized representatives with both SSA and FSSA will need to complete forms for both SSA and FSSA. SSA and FSSA do not have the same authorized representative form and do not share information on individual's designated authorized representatives.

5) Will the authorized representative for members receive the same communication that the member receives?

Yes. Identical notifications will be sent to members and to each of their qualified authorized representatives on file. Members may have up to three authorized representatives designated with the Medicaid Agency.

6) How does this transition impact authorized representatives?

Authorized representatives should be prepared to assist members with the transition. The roles of Medicaid authorized representatives do not change with this transition.

The majority of members that will experience coverage changes will be automatically transitioned, and neither the member nor the authorized representative will need to take action. Some Medicaid authorized representatives will need to help members establish a Miller trust. Additionally, if the member is referred to the Social Security Administration, the Health Insurance Marketplace, or to Medicare for supplemental coverage, the Medicaid authorized representative may need to complete the required authorized representative forms with these organizations, as the Medicaid authorized representative designation is only valid for Medicaid.

Waivers and Services

1) Will dually eligible waiver clients over 185 percent FPL lose that Medicaid eligibility?

Individuals on Medicaid waivers will remain eligible. Individuals with incomes up to the Special Income Limit, or \$2,163 per month, will not need to take any action. Individuals with incomes of over \$2,163 per month will need to establish a Miller trust to maintain eligibility. Please see the instructions for establishing a Miller trust for more information.

2) In reference to the Medicaid waiver program, will Senate Bill 30 continue to waive parental income for children under the age of 18?

The 1634 transition does not impact how parental income is treated for children under 18. Parental income and resources will not be considered when assessing children's eligibility for home and community-based waiver services.

3) In reference to the Aged and Disabled Waiver, does a waiver targeted person have to complete a Medicaid application?

These individuals will need to complete a Medicaid application to attain waiver eligibility. Individuals applying on the basis of disability that do not already have a pending or approved disability status with the Social Security Administration (SSA) will be required to apply to for Social Security Benefits. Individuals age 65 or older will not be required to apply to SSA for a disability determination, but will be required to apply for any Social Security Benefits they are eligible for and not currently receiving.

4) Will case managers be notified by the INSite help desk of changes in Medicaid for our waiver recipients?

Case managers will be notified of changes in Medicaid that impact waiver participants. There are approximately 226 identified waiver participants that will need to establish a Miller trust. Case Managers will be notified of members that need to complete this process prior to June 1st.

5) Other than spend down will there be any changes to Medicaid Waiver billing?

Providers will continue to bill Medicaid and then will recoup the patient's portion from the Miller Trust.

6) How will this affect Home Health prior authorizations (PA) that extend beyond June 1st, 2014?

Prior authorization (PA) for home health is based on a timeframe and number of units. If a member maintains Medicaid eligibility on June 1st, the home health PA will remain in effect through its expiration provided the member has not used all authorized home health units. If an individual loses Medicaid eligibility as of June 1st, the home health PA will no longer be valid due to ineligibility.

Procedures and Processes, misc.

1) Are you including state operated facilities (SOF) in the institutional population?

Individuals that are eligible for Medicaid while in an SOF, including those over 65 years of age or under age 21 with the appropriate certificate of need, are included in the institutional population. Members in state operated facilities that do not have Medicaid or have suspended Medicaid are not included in Medicaid's institutional population.

2) Will those who receive Medicaid based on SSI benefit still go into suspense when they go into a State Operated Facility (SOF)?

Yes. Members that are not over 65 or under 21 with the appropriate certificate of need will have their Medicaid suspended for 12 months when they enter a SOF. Members with suspended Medicaid that leave an SOF within 12 months will have their Medicaid eligibility reinstated. After 12 months in an SOF, members without SSI will need to reapply; however, receipt of SSI automatically grants Medicaid eligibility so individuals that receive SSI and leave an SOF will be automatically eligible to receive Medicaid without filling a separate Medicaid application.

3) Will transportation providers bill Medicaid, the client or the Marketplace provider or still Medicaid for former Medicaid spend down clients?

If the provider is billing after the transition for a service that occurred prior to the June 1 transition then billing should follow the current process. If the service occurred after the transition the provider should bill the client's new insurance provider or the client directly depending on if transportation is a covered service.

4) Will the Medicaid eligibility website indicate if a member has Medical Rehabilitation Option (MRO) coverage?

The Medicaid eligibility website indicates whether a member is or is not eligible for Medicaid. This website does not currently indicate if a member receives the MRO benefit and will not indicate this information in the future.

5) I apply for severely mentally ill patients in state operated facilities that are nearing discharge so their coverage will be ready when they transition to the community, will there be a new application process I need to use?

The process for State Operated Facilities (SOF) to follow to initiate an application for Medicaid will remain unchanged. Medicaid clients that had their Medicaid suspended and are leaving an SOF within 12 months of entry will have their suspended Medicaid reinstated without the need to file a new application. Such individuals must report the change to the Division of Family Resources (DFR) within 10 days of being discharged. New applicants and Medicaid clients that have suspended Medicaid but have resided in an SOF for more than 12 months will need to file a new application for Medicaid when leaving the SOF.

If during discharge planning with a Community Mental Health Center (CMHC) an individual is identified as potentially eligible for the Behavioral and Primary Healthcare Coordination (BPHC) program, the CMHC will need to initiate the application for determination of clinical eligibility. Receipts of Supplemental Security Income (SSI) are automatically granted Medicaid eligibility, so individuals that receive SSI and leave an SOF will be automatically eligible to receive Medicaid without filling a separate

Medicaid application. It should be reported to SSA and to the DFR that the SSI recipient is leaving the SOF.

6) If a person has terminal cancer and does not currently receive benefits from the Social Security Administration, can the individual still apply for Medicaid with the expedited form?

The current process and use of the expedited form for Indiana's Medical Review Team (MRT) will not change with the 1634 transition. MRT only determines whether a person meets the disability requirement. Members applying with the expedited form for a disability review will be required to meet all other Medicaid eligibility criteria including income and asset requirements, and filing an application with the Social Security Administration for disability benefits.

1915(i) Behavioral and Primary Healthcare Coordination Program

1) Will there be allowances for people in the serious mental illness population attempting a return to part-time employment?

Individuals with a serious mental illness may be eligible for the new 1915(i) BPHC program if they have income up to 300 percent of the Federal Poverty Level (FPL). These individuals will receive full Medicaid benefits and allowing individuals with income up to 300 percent FPL to qualify will allow for a return to part-time employment for these individuals. Disabled individuals returning to part time work may also be eligible for the MED Works program.

Skilled Nursing Facility Questions

1. If members have income over \$2,163 per month and reside in a skilled nursing facility how can they maintain Medicaid eligibility with the spend down program ending?

Members with income over the \$2,163 a month must establish a Miller trust to maintain Medicaid eligibility.

2. What happens to spend down recipients on June 1, 2014, if in a skilled nursing facility? Is Medicaid no longer in place?

Spend down members that are in a skilled nursing facility and have income over \$2,163 per month will need to establish a Miller trust to maintain Medicaid eligibility. Current spend down members who reside in skilled nursing facility have a spend down for one of two reasons: 1. A person is serving a transfer penalty period; or 2. The calculated income of the resident after applying all deductions is greater than the cost of care provided by the institution.

Individuals serving a transfer penalty period with income greater than \$2,163 per month in the initial eligibility step will be required to establish a Miller trust for the member to maintain their status as being considered categorically eligible for Medicaid while residing in a nursing facility. These members

will not have a spend down attached to their eligibility. Indiana Medicaid will continue not paying for the nursing home per diem during a penalty period.

For individuals under the second scenario, they will have a high liability where Indiana Medicaid will not pay for the facility for the care provided because the liability is higher than the cost of the care provided.

3. What happens June 1, 2014, if the institutionalized spend down recipient has not enrolled in the Behavioral and Primary Healthcare Coordination (BPHC) program?

Since the BPHC 1915(i) state plan amendment is a home and community based program, institutionalized individuals are not eligible for the BPHC program; however, individuals that have a planned discharge may be assessed and apply for BPHC and Medicaid eligibility determination prior to discharge. If eligible, 1915(i) BPHC Medicaid benefits would not begin until the individual was discharged from the institutional setting. The BPHC program provides full Medicaid coverage as well as coordination of behavioral and primary healthcare for individuals with serious mental illness up to 300 percent of the Federal Poverty Level.

4. Are there other programs other than Behavioral and Primary Healthcare Coordination (BPHC) that recipient can choose, as BPHC appears to be directed towards mental illness only.

The BPHC program was created to ensure that individuals with severe mental illness had access to Medicaid Rehabilitation Option services that are not available in commercial health plans. The state will continue their other Medicaid Home and Community Based waiver programs for individuals who meet the needs based criteria for one of the waiver programs. For more information on the Home and Community Based Medicaid Waiver Programs please visit www.fssa.in.gov.

In addition, members that are nearing discharge from a skilled nursing facility and are over 100 percent of the Federal Poverty Level may seek supplemental Medicare coverage or coverage on the federal Marketplace.

5. Will any training be held for nursing facilities?

Requests for additional training can be directed to office.communications@fssa.in.gov.