



Medicaid Spenddown: 2012 Brief

With the elimination of **Illinois Cares Rx**, more than 100,000 seniors and people with disabilities will lose assistance in paying for their Medicare Part D drugs. For many, the resulting increase in the cost of their drug coverage could mean choosing between paying for necessary medications or paying for food. One strategy to avoid this situation is enrollment into Medicaid. By enrolling in Medicaid, an individual becomes a **“dual eligible”** for Medicare Part D purposes, which, in turn, makes them eligible for the federal “Extra Help” program (also known as “Low Income Subsidy/LIS”). LIS provides the most assistance available in paying Medicare Part D costs.

For many clients and their service providers, the automatic qualification for LIS through Medicaid eligibility is very confusing. What is important to remember is that for all but a few categories of medications, it is NOT Medicaid that pays for the prescription drugs. It is Medicare Part D that is providing the prescription drug coverage. All the Medicaid eligibility provides for prescription drug coverage is cheaper co-payments under Medicare Part D by making the person eligible for LIS.

In effect, one health insurance – Medicaid, is making another health insurance – Medicare, cheaper.



Any former Illinois Cares Rx enrollees with little to no assets (excluding the home in which he or she resides and one car) should consider this option. Enrolling in Medicaid for at least **one month** qualifies an individual as a “dual eligible” for Part D purposes, and therefore automatically qualifies the person for assistance through LIS. Because they receive assistance through LIS, dual eligibles pay no or a low Part D premium, no deductible and maximum co-payments of \$2.60 for generics and \$6.50 for brand name drugs. (Note: It is critical to remember that to qualify for LIS, an individual only needs to qualify for Medicaid for **one month**. This is discussed in more detail on p. 3 of this brief.)

LIS coverage will provide a person with cost-sharing assistance that is *more* generous than what was provided by Illinois Cares Rx.¹ So what is the catch? These former Illinois Cares Rx enrollees will, in most cases, need to “spend down” to Medicaid eligibility as their income will be too high to qualify for Medicaid without a spenddown.

The chart below displays the costs of a Medicare Part D coordinating plan with Illinois Cares Rx assistance, the costs of Medicare Part D in those same plans without assistance, and the costs in those plans with dual eligible status.

- **Keep in mind, though, that now that Illinois Cares Rx has ended, there is no guaranteed benefit to staying in an Illinois Cares Rx coordinating plan.** Individuals may want to consider switching to a different Part D plan and can do so through August 31, 2012. However, for cost comparison purposes in this brief, comparing prices over the same set of plans is simplest.

Comparison of Costs for Beneficiaries on Illinois Cares Rx Coordinating Medicare Part D Plans			
	Medicare Part D Costs with Coordinating Plan and Illinois Cares Rx	Without Illinois Cares Rx	With Dual Eligible Status (automatically qualify for LIS)
Premium	\$0	\$26.70-\$34.20	\$0 or \$4 for AARP Plan
Deductible	None	\$0-\$320	None
Co-Payments up to Total Drug Costs of \$2930	<ul style="list-style-type: none"> • \$0-\$5 generic drugs • \$15 or \$20 brand-name drugs • \$15 specialty drugs 	<ul style="list-style-type: none"> • \$0-\$6 generic drugs • \$39 to \$95 brand-name drugs or 19%-35% of the cost of the brand-name drug • 25%-33% of cost of the specialty drugs 	<ul style="list-style-type: none"> • \$0-\$2.60 generic • \$0-\$6.50 brand
Coverage Gap (“Donut Hole”)	25% plus copayment for generic and brand-name drugs	86% of the cost of the generic drug, 50% of the cost of the brand-name drug	<ul style="list-style-type: none"> • \$0-\$2.60 generic • \$0-\$6.50 brand
Medicare Part D Excluded Drugs on the Medicaid Formulary	Covered under same rules as above	Not Covered	Only Covered if Enrolled in Medicaid that month.

¹ Illinois Cares Rx did provide assistance in paying for prescription drugs excluded by Medicare Part D but covered by Illinois Medicaid. LIS will not provide assistance with this. However, if the person is enrolled in a particular month in Medicaid, Medicaid will cover that drug for that month.

How Does Dual Eligible Status Work For Medicare Part D?

Dual eligible status for Medicare Part D purposes can be very confusing. It is easier to understand if you know how the process works “behind the scenes.” States determine who is eligible for Medicaid. In Illinois, this is done by the Illinois Department of Healthcare and Family Services (DHS). The federal government (Center for Medicare and Medicaid Services) handles Medicare eligibility. So, in order to find out who is enrolled in Medicaid and should therefore be enrolled in Medicare’s LIS, the states must share their Medicaid eligibility lists with the federal government. Because people go in and out of Medicaid eligibility all the time, an administrative nightmare would result if the federal government had to re-determine dual eligible status based on those lists shared by the states. In addition, beneficiaries would experience mass confusion if their prescription drug cost sharing responsibilities changed as often as their enrollment in Medicaid did. Therefore, the system is designed to offer some predictability in eligibility for Medicare recipients.

Dual eligible status works like this:

- If you are enrolled in Medicaid in January, February, March, April, May or June, you will be determined to be a dual eligible for Medicare Part D purposes and automatically qualify for LIS for the month you become eligible for Medicaid and every subsequent month during that *same calendar year*.
- If you are enrolled in Medicaid in July, August, September, October, November, or December, you will be determined to be a dual eligible and automatically qualify for LIS for the month of Medicaid eligibility and every subsequent month during the same calendar year *and* the next calendar year.

What does this mean in practice? If a person is enrolled in Medicaid (meets their spenddown) in July or any subsequent month of 2012, he or she is considered a dual eligible and will automatically receive LIS for the rest of 2012 and 2013. **Even if the person is only in Medicaid for just *one month*, this extended LIS status will apply.** Here are two examples:

- If Judy uses medical bills to meet her spenddown and qualify for Medicaid in April of 2012, Judy will also qualify for LIS from April 2012 through December 2012.
- If Joe meets his spenddown in August 2012 by showing his caseworker that he paid Medicare Part B premiums for the last 6 months, Joe will qualify for LIS from August 2012 through December 2013.

What Is Medicaid Spenddown?

In Illinois, anyone meeting the non-financial requirements of Medicaid who is over the age of 65, disabled or blind could qualify for what is called “AABD (Aid to Aged Blind

and Disabled) Medicaid” by spending down their income and assets to Medicaid levels. Click [here](#) to view the non-financial requirements for AABD Medicaid.

For those meeting these requirements (countable incomes up to 100% of the Federal Poverty Level and resources up to \$2000 for an individual and \$3000 for a couple), Medicaid eligibility can be provided immediately. For those whose incomes are above 100% of the Federal Poverty Level and/or assets are above \$2000(single) or \$3000 (married), Medicaid eligibility only happens after a spenddown has been met. Spenddown is a determined amount of medical bills that a person must incur or spend in qualified medical services.

By definition, all former Illinois Cares Rx enrollees with Medicare meet the age or disability requirement for AABD. If they meet all other non-financial criteria, then the only thing left to determine is what that spenddown will be. For some, meeting the spenddown has too many downsides - perhaps they are unwilling to spend the nest egg of \$10,000 that they have in the bank, for example. However, there are many others who could meet their spenddown to gain dual eligible status and lower cost sharing for Medicare Part D without much down side at all.

How Is Spenddown Calculated?

There are two types of Medicaid spenddowns: income spenddowns, and asset spenddowns. To qualify for Medicaid, an individual may need to meet an income spenddown, an asset spenddown, or both.

Income Spenddown

A person’s income spenddown is the difference between that person’s countable income and 100% of the Federal Poverty Level (FPL). Countable income for Medicaid purposes is *not* the same as gross income. There are deductions that are taken from gross income to get to countable income. Those deductions include:

- \$25 general income disregard (this means that *everyone* who applies for Medicaid can disregard \$25 of their income)
- Employment Income Expenses including:
 - Withheld income taxes (federal, state or city)
 - Social Security tax
 - For aged and disabled individuals, the first \$20 of earned income plus ½ of the next \$60
 - For blind individuals, the first \$85 of earned income plus ½ of the amount over \$85 and for those with an approved plan for self-support, any amount of income necessary for fulfillment of the client’s plan for a period not to exceed 12 months. The plan must be approved by the Zone Administrator.
 - Other miscellaneous expenses listed [here](#).

For example: Mary receives Social Security Disability Insurance (SSDI) of \$1000 per month. We will only include the applicable deductions from above. Her spenddown would be calculated as follows:

Gross Income	\$1000
Minus General Income Disregard	<u>-\$25</u>
Countable Medicaid Income	= \$975
Minus 100% FPL Comparison	<u>-\$931</u>
Spenddown Amount	= \$44

Asset Spenddown

A person's asset spenddown is the difference between the person's countable assets and the Medicaid asset limit (\$2,000 for an individual or \$3,000 for a couple). For Medicaid purposes, "countable assets" are any resources other than the person's home (that the person lives in) and car.

For example: if Jim is 70 years old and his income is below 100% FPL (and he meets the other non-financial Medicaid requirements referenced above), and his only assets are \$3,000 in a savings account, Jim's asset spenddown will be calculated as follows:

Total Assets:	\$3,000
Minus Medicaid Asset Limit (for single individual)	<u>-\$2,000</u>
Spenddown Amount	= \$1,000

What Types Of Medical Expenses Count?

Particularly important to former Illinois Cares Rx enrollees, **premiums paid for Medicare count toward Medicaid spenddown if the person is not enrolled in a Medicare Savings Program that pays that premium for them.** This means that, right away, most Illinois Cares Rx enrollees with no other assistance available to them have at least Medicare Part B premium expenses that can count toward spenddown. **A person does not need to show proof of payment of Medicare premiums.** They should tell their caseworker that they pay a premium and the caseworker can verify this.

In addition, any medical expenses covered by Medicaid or otherwise recognized by state law can be used including:

- Expenses for care under the DRS Home Services or Community Care Program
- Doctors services
- Hospital services
- Nursing home services
- Clinic services
- Dentist services
- Podiatrist services
- Chiropractor services
- Medicines, medical supplies and equipment prescribed by a doctor
- Eyeglasses
- In-home medical or personal care
- Health insurance premiums, **including Medicare and Medicare Supplement (Medigap) premiums**
- Speech, occupational and physical therapy
- Transportation to and from medical care
- Co-payments or deductibles, **including those under Medicare**

These expenses can be for the individual, his or her spouse, and his or her children under 18 who live with the individual.

How Does Somebody Meet This Spenddown Amount?

There are three usual ways to meet spenddown: submit unpaid bills, submit paid bills, or pay the spenddown. Bills or receipts should include type of medical care, drugs or supplies, who gave the care, who got the care, the date the care was given, the cost, the date of the bill or receipt. You can use any or all of these methods in a given month. Here is how they work:

Unpaid Bills: Unpaid bills can be used to meet spenddown no matter when the actual service was performed. The key to having an unpaid bill count is that it is a “current bill.” A current bill is a bill with billing date (month and year) that is within 6 months of the month that the client wants to use the bill to qualify for Medicaid. So, if the bill is dated in January 2012, it can be used to meet spenddown in any month from January through July of 2012. A person can ask for a new bill from their provider dated within the past six months if they don’t have a recent one. (Note: If unpaid bills are used to meet spenddown, Medicaid will *not* pay for those bills.)

Receipts for Bills Paid: Paid expenses can be used to meet spenddown. Here, an individual can use the bill for the month paid and for six months after the payment is made. So, a bill paid in January 2012 can be used to meet spenddown in January or any month through July of 2012. This is where Medicare Part B or Medicare

Supplement premiums paid can be used. For a July Medicaid application, the individual can request that the Medicare Part B premiums for January-July be used to meet the spenddown in July. (Remember – an individual does *not* need to provide proof of paid Medicare Part B premiums. The person simply needs to tell the caseworker that they paid Part B premiums that should be counted toward the spenddown. The caseworker can verify this.)

Pay-In Spenddown: Some individuals may choose to simply pay the monthly spenddown amount or a portion of it. This can include individuals who do not have enough in medical expenses to meet their spenddown amount. In order to do this, the person must sign up for the Pay-In Spenddown program. An individual is not allowed to just go into their local DHS office and write out a check to the caseworker. Rather, he or she signs up and is sent a Pay-In Spenddown Statement. The statement and payment must then be mailed back to HFS Fiscal Operations. To enroll in Pay-In Spenddown, an individual must fill out and submit the [Pay-In Spenddown Enrollment Form \(HFS 458SP-4\)](#).

When Is The Medicaid Enrollment Effective?

The effective date of Medicaid eligibility can be confusing, especially when spenddown is involved. If an individual is using Medicaid eligibility to attain dual eligible status and automatically qualify for LIS, he or she is going to want that Medicaid enrollment to be effective July or later so that the dual eligible status lasts for the current year and the entire next year. Otherwise, the individual will be back trying to meet spenddown sooner than he or she needs to do so. The easiest way to time this right and avoid confusion is to apply for Medicaid in July or later. A couple of things to keep in mind:

- An individual can be eligible for Medicaid up to 3 months prior to the month of application if they meet spenddown for those months. This can be helpful in paying back bills for many individuals. But if the person wants the dual eligible status for Medicare Part D for the rest of the year and the following year, he or she may not want to use Medicaid to cover the bills from those past months if it means there will not be enough expenses left to meet Medicaid eligibility in July or later.
- In general, when an individual meets spenddown with medical expenses, they qualify for Medicaid on the day in the month that the medical bills and receipts show that spenddown has been met. However, an individual can request that the expenses be used to meet spenddown for a later month to get a full month's coverage.
- The key is to make sure the caseworker knows the individual wants Medicaid coverage in July or later in order to maximize that dual eligible status. However, even if it does not work out that way, the individual will still be covered for the current year. They will just need to try to "spenddown" again for next year.

What Is The Best Evidence Rule and How Can That Be Helpful Once Medicaid Eligibility Is Effective?

As discussed earlier, once a person is enrolled in Medicaid, their name is shared with the federal government (Center for Medicare and Medicaid Services), who will automatically enroll them in LIS. That status then needs to be reported to the individual's Medicare Part D Plan. None of this happens in real time. So, just because a person is determined eligible for Medicaid as of July 1, 2012, it does not mean that if they go into the pharmacy on July 15, 2012, they will be correctly charged the small LIS co-payment of a dual eligible.

In order to address this issue, the Center for Medicare and Medicaid Services (CMS) created the Best Available Evidence Policy. Under this policy, individuals can establish dual eligible status before the Part D plan gets the official notice from the federal government to prove they automatically qualify for LIS. The Medicare Part D plan is required to accept evidence of Medicaid eligibility, such as the sheet of paper provided by Illinois Department of Human Services when somebody is enrolled in Medicaid, so they can apply the correct LIS co-pays . If the individual does not have such evidence but alleges he or she is enrolled in Medicaid, the Medicare Part D plan is required to help the individual secure evidence of his/her Medicaid coverage. Once evidence is submitted, the Medicare Part D plan must then treat the person as a dual eligible and provide them with their medications at the LIS cost sharing amounts.

If individuals are charged the wrong amount at the pharmacy after Medicaid eligibility status is established, it is likely because the Medicare Part D plan has not yet been informed of the individual's dual eligible status. The individual or anyone providing assistance should call the Medicare Part D plan and inquire about their Best Available Evidence Policy procedures and follow them to submit the necessary evidence.

Summary: From Illinois Cares Rx To Dual Eligible

Assess for Medicaid Spenddown Eligibility	Apply for Medicaid	Utilize Best Available Evidence Policy
<ul style="list-style-type: none">• What are the person's non-exempt assets?• What is the person's countable income?• Including Medicare premiums, what are the last 6 calendar months of medical expenses that can be shown in bills or receipts?• With a rough estimate, could the person meet the spenddown to 100% FPL with this countable income and those medical expenses?	<ul style="list-style-type: none">• Gather and take in all relevant receipts, bills, etc.• Try to meet spenddown on application day by submitting those receipts and/or bills right then and there, and reminding the caseworker to count Medicare premiums.• Make sure eligibility is effective in July or later.• If applicable, request and fill out form for pay-in spenddown.	<ul style="list-style-type: none">• Attempt to fill prescriptions at the pharmacy.• Remember if not charged a small co-payment, there is a problem.• Call the Medicare Part D Plan and inquire about the Best Available Evidence Policy• Submit evidence of Medicaid eligibility as requested.• Go back to the pharmacy and pick up medicine at the correct cost!

What Else Would Be Helpful To Know Before I Start This Process With A Client?

- Submit all unpaid bills and receipts with the application. This will allow them to determine eligibility more efficiently and save an extra trip to submit bills to meet spenddown later.
- A Medicaid Medical benefits application will not be approved unless you provide enough documentation of medical expenses to meet spenddown for 1 month. **(Remember – the individual only needs to meet spenddown *once* between July and December to automatically qualify for LIS for the remainder of this year and all of next year.)**
- Get to know your local DHS Office Managers and Secretaries. Local offices hold Community Quality Council (CQC) Meetings – it is a good idea to attend these meetings and get to know your local office staff.
- Do not try and contact your local DHS office on a Monday or at the beginning of the month.
- Ask your local DHS office for their preferred method of receiving documentation. Ask if they would like you to address all documents to a specific person or area.
- If you are going to apply on-line make sure your application is flawless. Also, if you do an on-line Medicaid application, make sure you fax or scan/email all required documents to the local office. Mention that you have just completed an online application and that these are the supportive documents.
- Make sure all documents submitted with an application have the clients SS# clearly marked on all pages.

- If your clients go to their local DHS office, make sure they sign into the VIS System (Visitor's Information System). This way, DHS will have a record that they were in the office and cannot deny receiving documents.
- Some of the local DHS offices have transitioned to a system called Case Banking, which means that clients will not have an assigned case worker but a team. The office managers serve as contact points for clients.

Additional Resources

The Illinois Medicaid application is HFS Form 2378B, which can be downloaded here: <http://www.dhs.state.il.us/OneNetLibrary/27897/documents/Forms/IL444-2378B.pdf>

To fill out a Medicaid application online, visit the Illinois Department of Human Services (DHS) website here: <http://fspp.dhs.state.il.us/register/wb/wbHomePre.do>. To locate a local DHS (Medicaid) office, [click here](#) and select "Family and Community Resource Center" as the type of office along with the county and zip code. (Note: An individual may apply for Medicaid at any DHS office. However, if an individual has a current active case, s/he should apply at the original office, then request a transfer to a different office if necessary. Cases may only be maintained by one DHS office at a time.)