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October 12, 2012

MEMORANDUM

TO: The Honorable Walter A. Stosch, Chair
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

The Honorable Linda T. Puller
Chair, Joint Commission on Health Care

FROM: Cynthia B. Jones Cynthia B. Jones

SUBJECT: Report on the Reduction of the 300% of SSI Income Limit

Item 307 (KKK) of the 2012 Appropriations Act requires the Department of Medical Assistance Services to provide a detailed report and analysis of the impact of the reduction of income eligibility from 300 percent to 267 percent of Supplemental Security Income (SSI) on current Medicaid recipients. The report is due to Chairmen of the Senate Finance and House Appropriations Committees and the Joint Commission on Health Care by October 1, 2012. I have enclosed for your review the report for 2012.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

Enclosure

Cc: The Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources

Reduction of the 300% of SSI Income Limit

Department of Medical Assistance Services

October 2012

Introduction

Item #307 KKK of the 2012 Appropriations Act directs the Department of Medical Assistance Services (DMAS) to take two actions related to the Medicaid eligibility group for institutionalized individuals, the 300 percent of the Supplemental Security Income (SSI) group:

1. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to reduce the income limit for eligibility under the 300 percent Supplemental Security Income (SSI) eligibility group to 267 percent of the SSI payment level. The department shall implement this change effective January 1, 2014, or the earliest date thereafter when it is determined that such change is in compliance with the maintenance of effort requirements of §2001 of the federal Patient Protection and Affordable Care Act (P.L. 111-148).

2. Prior to the implementation of the reduction in paragraph KKK 1., the Director of the Department of Medical Assistance Services shall provide a detailed report and analysis of the impact of the reduction of income eligibility from 300 percent to 267 percent of Supplemental Security Income (SSI) on current Medicaid members. The report shall include a comprehensive review and analysis of the estimated savings, costs and effects of the eligibility change.

This document is intended to meet the requirements specified in Item 307 KKK.2.

Discussed in more detail below, the Department has examined the implications of the reduction in the income limit for the SSI group and determined that the savings previously estimated are not realistic given various factors related to eligibility for Medicaid in Virginia. These factors are primarily related to continued eligibility for nursing facility coverage under Medically Needy coverage rules despite the income threshold reduction in the SSI group, refilling of vacated waiver slots under the Intellectual Disabilities (ID) and Family Developmental Disabilities Support (DD) waivers with individuals on the waiting lists, substitution of the Elderly or Disabled with Consumer Direction (EDCD) waiver services for individuals vacating ID and DD waivers due to excess income, and required phasing of the reduction over the fiscal year.

The Department estimates that some savings will still be achieved through the income threshold reduction, but the level of savings is estimated at $4 million ($2 million GF) in FY 2014. Previously, the Department estimated this Appropriations Act provision would save $24.5 million ($12.3 million GF). This estimate and implications of the income threshold reduction are discussed below.

300 percent of Supplemental Security Income group

Medicaid is required by federal law and regulation to cover certain groups of individuals: those who are age 65 or older, those who have been determined to be blind or disabled, children under the age of 19, parent/caretaker relatives and pregnant women. In addition to the groups of

individuals that Medicaid programs must cover, there are also optional coverage groups or groups of individuals that Medicaid programs are not mandated to cover, but can choose to cover. The 300% of Supplemental Security Income (SSI) group is one such optional group that the Virginia Medicaid program has opted to cover.

Individuals covered in this group are those who have income in excess of the limits to receive coverage in another full benefit Medicaid coverage group, but who have been determined to need the level of care provided in an institutional setting such as a nursing facility or an intermediate care facility for individuals with intellectual disabilities (ICF/ID), or in the community through one of Medicaid's home and community based service (HCBS) waivers. To be eligible in the group, an individual must meet all Medicaid non-financial requirements and have countable resources that do not exceed the $2,000 limit and income within 300% of SSI (currently up to $2,094 per month). Eligible individuals in this group receive Medicaid coverage of their long-term care services as well as coverage for all other medically necessary services covered by the Virginia Medicaid program.

Not every state has elected to cover individuals either in this group or up to this level. Thirty-eight states currently cover this group; however, two states, Alaska and Delaware cover these individuals at an income level less than 300% of SSI. Alaska's income limit for this group has been frozen at $1,656 per month, and Delaware covers individuals in this group with income up to 250% of SSI ($1,745 per month).

Impact of reducing the income limit

A reduction of the income limit from 300% of SSI to 267% of SSI will first require a redetermination of eligibility for every individual enrolled in this coverage group to see who may be impacted by the change. Medicaid cases for individuals receiving long-term care services are maintained in paper files in 120 local departments of social services across the state. The process to evaluate these individuals and determine who will be impacted by the change will be largely a manual process utilizing information that only exists in the local departments of social services across the Commonwealth (some localities may have access to electronic data, but many, if not most, likely do not). It is not clear how many redeterminations would take place because there is no systematic income data available to DMAS. Previously, the Department estimated that the reduction would affect 3,068 individuals, so the number of reviews would be somewhat higher than that figure.

Individuals with income at or below 267% of SSI will see no change in their eligibility as a result of the reduction in the income limit and redetermination of eligibility. Individuals with income above 267% of SSI will see a change in their eligibility as a result of the redetermination. Due to income being in excess of the 267% of SSI limit, they will be evaluated as Medically Needy and placed on a spenddown. A spenddown is like an insurance deductible. In order to achieve a

limited period of eligibility for full Medicaid coverage, the Medically Needy individual must incur medical or remedial care expenses that equal or exceed his spenddown. When the required amount of expenses has been incurred, the individual can be enrolled for full Medicaid coverage for a limited period of time. For individuals receiving long-term care services, the time period for incurring expenses is one month.

Federal regulations allow Medicaid programs to project expenses for nursing facility residents when determining whether or not a Medically Needy spenddown will be met. The facility's monthly Medicaid rate is compared to the individual's spenddown liability amount. If the amount of the spenddown liability is less than the facility's monthly Medicaid rate, the individual will continue to be eligible for full Medicaid coverage, including payment of his long-term care expenses. Individuals residing in nursing facilities, who are impacted by the reduction in the income limit, will continue to be eligible for full Medicaid coverage as their spenddown liability amount will always be less than the facility's Medicaid rate for the month.

Federal regulations do not allow Medicaid programs to project expenses for Medicaid HCBS waiver participants when determining whether a spenddown will be met. This means eligibility workers in local departments of social services will need to obtain verification of the actual costs of medical expenses incurred each month and compare the incurred expenses to the individual's monthly spenddown amount. If the amount of actually incurred expenses equal or exceed the individual's spenddown amount, that individual can be enrolled in Medicaid for the month. No ongoing coverage exists in this situation; there will be a month to month calculation that cannot take place until the expenses have actually been incurred. Most individuals receiving HCBS waiver services, such as those receiving supports through the Elderly or Disabled with Consumer Direction (EDCD) Waiver, can be evaluated as Medically Needy and incur expenses in order to try and achieve eligibility each month.

However, the Medicaid benefit package for Medically Needy individuals differs from the benefit package provided to other full benefit Medicaid eligibility groups. Due to this difference, some individuals currently receiving full coverage through Medicaid will not be eligible for the same coverage once income limits are reduced.

The Medically Needy benefit package does not include coverage of services in an ICF/ID. Therefore, while individuals in an ICF/ID with income at or below 267% of SSI can continue to receive services in the facility, there will be no ability for individuals with income above 267% of SSI to be able to spend down to achieve eligibility in the facility.

In addition, there are two HCBS waivers for which being evaluated as Medically Needy is not possible; the Intellectual Disabilities (ID) Waiver and the Individual and Family Developmental Disabilities Support (DD) Waiver. Once the income limit is reduced from 300% SSI to 267% SSI, individuals in those waivers with income in excess of the limits will lose all Medicaid coverage, including coverage for waiver services. There are no provisions for individuals to

spenddown to achieve eligibility in the ID and DD Waivers. Since they will no longer be receiving waiver services, they will be treated as non-institutionalized individuals, and their spenddown will be calculated over a six month period instead of a one month period. It is unlikely that these individuals will incur medical expenses sufficient to meet their spenddown. Some of these individuals may have waited years to receive their waiver slot, and will no longer receive the long-term supports that enabled them to remain in the community.

While certain individuals currently enrolled in these waivers will lose coverage due to the reduction in the income limits, their slots may be filled by someone currently on the waiting list. As a result, it is anticipated there will be no overall reduction in the enrollment in the waivers as individuals currently on the waiting list will move up and begin to receive ID or DD Waiver services.

Federal maintenance of effort requirements dictate that states cannot reduce eligibility levels in their Medicaid programs until January 1, 2014 or the date a health insurance exchange (whether federal or state managed) is operational in the Commonwealth. Because of this requirement, local departments of social services will be directed to implement this reduction in income limits beginning in 2014 at the time of the individual's annual redetermination of eligibility if a health insurance exchange is operational on January 1, 2014. It will take one year to re-evaluate all individuals receiving long-term care services under the new income limit. Phasing in the move may also allow certain ID and DD Waiver participants who would be impacted by this change to remain in services until the time of their annual redetermination of eligibility rather than lose eligibility in a mass change on January 1, 2014. If a health insurance exchange is not operational by January 1, 2014, this change will be delayed until the effective date the exchange becomes operational.

Potential Cost Savings

As part of the budget language, the Department of Medical Assistance Services was asked to detail what cost savings the agency could expect to receive by reducing the income limit from 300% SSI to 267% SSI.

The initial proposal to reduce the income limit was to roll the limit back from 300% of SSI to 250% SSI and was estimated to save $36.4 million ($18.2 million GF). The final proposal adopted in the 2012 Budget Act reduced the eligibility limit to only approximately 267% of SSI (200% of the Federal Poverty Limit) and was estimated to save $24.5 million ($12.3 million GF).

The estimates assumed a January 1, 2014 implementation; however, the Department has determined that a staggered implementation based on the individual's annual redetermination of eligibility will be the best way to implement the change. This will dramatically lower the estimated savings during the first year. Because the individuals in the Elderly or Disabled with

Consumer Direction (EDCD) Waiver would be able to qualify via a spenddown and while those in the ID or DD Waivers or in an ICF/ID are still vulnerable to the cuts, this eligibility change will not offer much in savings to the Commonwealth.

If an ID or DD Waiver participant fell into the income range between 267% and 300% SSI, the individual may be cut from the waiver, but may still qualify for services in the EDCD Waiver by meeting a spenddown. Meanwhile, the ID or DD Waiver slot the individual occupied would become available for another person. Twenty five percent of individuals on the ID Waiver waiting list are currently receiving services through the EDCD Waiver, so there is a chance DMAS would simply see a shifting of expenditures from one individual to another as opposed to a net reduction in covered individuals. The individual receiving a slot in the ID or DD Waiver could be someone from the waiting list not currently receiving Medicaid, so these would be considered new expenditures. Some ICF/ID residents may lose eligibility, but they may find themselves in alternate care (and the empty ICF/ID bed may be refilled).

DMAS has also reconsidered the assumption that the numbers of ID and DD Waiver participants and ICF/ID residents are evenly distributed along the income scale. DMAS does not have income information for Medicaid members, so the Department routinely relies on even distributions through income ranges that can be found via the census. This is troubling and, in this case, should not be considered a reasonable assumption. The proposal to reduce the income limit to 250% SSI was estimated to affect 4,562 individuals; the final proposal was estimated to affect 3,068. It is now estimated the income limit will affect far fewer people than previously thought. Also, those that are affected will likely find other Medicaid paid care and vacated waiver slots will be refilled quickly by other individuals. This churning will produce some savings as new HCBS Waiver participants take time to find their care. Without income information on Medicaid members, DMAS cannot say how many people would be affected, but estimates the proposed eligibility change would save $4 million ($2 million GF) in FY 2014.

Conclusion

This report was prepared in response to Item #307 KKK of the 2012 Appropriations Act which directed DMAS amend the State Plan for Medical Assistance to reduce the income limit for eligibility under the 300 percent Supplemental Security (SSI) eligibility group to 267 percent of the SSI payment level. Additionally, DMAS was directed to provide a detailed report and analysis of the impact of the reduction of the income limit and include in the report a comprehensive review and analysis of the estimated savings, costs and effects of the eligibility change.

DMAS has determined that far fewer individuals than first expected will be impacted by this change, and any savings the Medicaid program could expect to see as a result will be far less than previously estimated. It is estimated those individuals receiving nursing facility or EDCD

Waiver services will be minimally impacted. However, those individuals who receive ICF/ID services or those individuals in the ID and DD Waivers may be adversely impacted and lose Medicaid eligibility. This could be especially problematic for DD or ID Waiver participants who may have waited years to access a waiver slot, and who may not otherwise be eligible for Medicaid services. It is now estimated the proposed eligibility change would save $4 million ($2 million General Funds) in Fiscal Year 2014.

In addition, federal maintenance of effort requirements dictate that states cannot reduce eligibility levels in their Medicaid programs until January 1, 2014 or the date a health insurance exchange (whether federal or state managed) is operational in the Commonwealth. If a health insurance exchange is not operational by January 1, 2014, this eligibility change will be delayed until the effective date the exchange becomes operational. This would thereby delay the cost savings estimated for Fiscal Year 2014.