MEMO

Re: Spenddown Eligibility Systems

Date: 10/13/04

**Michigan’s Problems:**

1. **Cumbersome verification process delays or prevent use of spenddown Medicaid**
   Even individuals with relatively small spenddowns (usually parents/caretakers) and those who meet their spenddown every month (usually clients who are elderly or who have disabilities, and regularly incur prescription expenses or Community Mental Health bills in excess of their spenddowns), must submit paper verifications that their spenddown has been met and must wait for an FIA caseworker to determine that they are eligible for Medicaid—a process that often takes weeks and frequently results in the client being unable to use the Medicaid coverage to access treatment and services while it is/was in effect. The “standard of promptness” for FIA processing of reported medical bills is 15 work days.

2. **Treatment is delayed or denied because providers cannot easily verify recipients’ spenddown status**
   Providers are unable or unwilling to provide treatment or services on credit without official verification by the state of the amount of the individual’s spenddown, and of the availability of Medicaid to cover expenses that exceed the spenddown amount. Providers cannot verify the amount of the recipient’s spenddown on the state’s eligibility verification system.¹ Very few providers’ offices are willing to make the effort to contact FIA caseworkers to determine a client’s spenddown amount.² Most providers will not extend credit based only on individuals’ FIA notices showing their spenddown amount.

**Possible/partial solutions from other states:**

1. **Using the eligibility verification system to speed up the spenddown eligibility process**
   In California, the state eligibility worker determines the individual’s spenddown amount and enters it into the state’s eligibility data base. That data is then transferred to the

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¹ Reportedly, the spenddown amount was available on the verification system in the past, but no longer is available because FIA considers the spenddown amounts posted by its caseworkers on its system to be inaccurate or unreliable.
² Due to early retirements, growing caseloads, and other factors, contacting caseworkers in most counties is a difficult and time-consuming task.
eligibility verification system, which is operated by EDS. The systems also use Medicaid case numbers to cross reference this data with any other Medicaid group members (such as a spouse) whose spenddown may be reduced based on the individual’s incurred medical bills. California’s eligibility verification system then allows both enrolled Medicaid providers and state eligibility workers to enter “share of cost” (their name for spenddown) transactions, reducing the spenddown by the amount of the incurred bills that are entered into the verification system. The provider or the eligibility worker enters information on the date of service, the recipient ID number of the person who received the service, the billed amount, the procedure code, and the provider ID number to assure that the share of cost is taken into account if the provider later bills Medicaid for the service.

If the medical expense is equal to or in excess of the share of cost (spenddown), the eligibility verification system automatically determines and reports that the individual is eligible for Medicaid for the entire month. Medical expenses are applied to the share of cost in the order that they are entered into the eligibility verification system, not by date of service. The share of cost transaction is not a billing transaction, which must be done separately by the provider.

The share of cost can be “cleared” or reduced by enrolled providers or by county eligibility workers using a point of service device, telephone/voice eligibility verification system, or internet application. Clearance is real time. The county eligibility worker can enter expenses incurred for services not covered by Medicaid, or for those furnished by a non-enrolled provider, or for other expenses that are not entered into the system by the providers. The system keeps a log of eligibility verification system transactions and gives providers an EVC number for tracking purposes.

A different process is used for folks in long term care.

This system for handling spenddown eligibility was developed as part of California’s plastic card system, which was contracted in 1992 and became operational in March 1994.

California contact people:
Donna Beeson – EDS – (916)464-0903
Craig Yagi – DHS-MCPD - CYagi@dhs.ca.gov

2. Using the provider billing system to streamline and speed up the spenddown eligibility process--
In Minnesota, as in Michigan, providers can use the eligibility verification system to check whether the individual has an unmet spenddown amount, but they are unable to find out the amount of the recipient’s spenddown. Unlike Michigan, however, providers in Minnesota can find out the amount of the recipient’s unmet spenddown by calling the Minnesota agency’s central office rather than the local caseworker. In addition, when providers do real time billing for items with a cost in excess of the spenddown amount, they immediately are informed how much of the bill must be paid by the recipient to meet their spenddown. Pharmacists in Minnesota can do real time billing through point of
service devices and all Medicaid-enrolled providers can do real time billing for individual bills through a web-based system. Providers who do batch billing receive notice of spenddown amounts the following day.

However, even after the provider has billed Medicaid for a medical expense that exceeds the individual’s spenddown amount, the Minnesota billing and eligibility verification systems do not identify the spenddown as having been met and the individual as being Medicaid eligible, until the Medicaid payment for the bill is issued. Medicaid provider bills are only paid every two weeks. Therefore, it may take almost as much time to establish eligibility under the Minnesota system as it does under the Michigan system.

Minnesota’s county financial eligibility workers establish and adjust spenddown amounts based on the individuals’ reported income and on medical expenses that are not billed through the state’s MMIS system. After a spenddown has been “cleared” and providers have been paid, Minnesota will not retroactively increase the spenddown amount, except for recipients in long term care. However, Minnesota may reduce spenddown amounts retroactively, in which case the state system automatically recalculates and sends out Medicaid payments to providers, who are expected to reimburse the recipient for any amounts that have been overpaid.

Minnesota’s basic system has been in place since 1994, with significant updates since then.

Minnesota contact person:
Pat Raschio – MDHS Claims Supervisor  (651) 296-7856.

3. Using a “pay in” option to streamline and speed up the spenddown eligibility process for recipients who choose to pay in--

Several states, including Utah, Minnesota, and New York, allow individuals the option of paying the amount of their monthly spenddown to the state in order to establish eligibility for full Medicaid coverage for the entire month or months covered by the pay-in. (Some states allow a 2-month or 6-month buy in option.) Of course, this option is most useful when an individual has a low spenddown amount. In Utah, for example, the state uses income disregards to allow elderly and disabled individuals to qualify for Medicaid by spending down to poverty level.

Suggested changes:

1. Require FIA to accurately determine monthly spenddown amounts for all recipients on an annual basis and when the recipient reports relevant changes;

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3 The web-based system is expected to be operational at the end of October 2004.
4 Providers can change or delete the billing prior to the payment date.
2. Require FIA to make up-to-date spenddown amount information available to DCH and to Medicaid enrolled providers in a timely and convenient manner;

3. If not already in place, establish a computer system that will cross-reference all spenddown Medicaid cases toward which FIA should be counting an individual’s medical expenses.

4. Develop a system that will allow both enrolled providers and FIA eligibility workers to input information about incurred expenses into the system, and will promptly and automatically adjust the recipient’s unmet spenddown amount and eligibility status based on the input information;

5. Develop a system that will provide accurate, up-to-date information to providers regarding recipients’ unmet spenddown amounts;

6. Develop an optional Medicaid “pay in” system that will allow recipients to establish Medicaid eligibility for the entire month in advance, by paying the amount of their spenddown to the state.

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