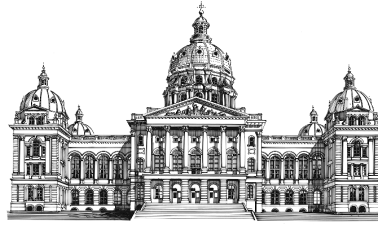

Iowa Legislative Fiscal Bureau

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State Capitol
Des Moines, IA 50319
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Medically Needy Program

ISSUE

Evaluation of the Medically Needy component of the Medical Assistance Program.

AFFECTED AGENCIES

Department of Human Services (DHS)

CODE AUTHORITY

Chapter 249A, Code of Iowa

BACKGROUND

The Medically Needy Program is intended to provide medical coverage to individuals whose income or assets exceed the maximum to qualify for the Medical Assistance Program but have large medical bills. Eligible individuals receive Medical Assistance Program coverage either on a two-month, six-month, or 12-month basis, depending on the eligibility group to which they belong. Coverage includes the full range of services available to other Medical Assistance Program clients (inpatient and outpatient services, prescribed drugs, etc.) except for nursing facilities.

The Medically Needy Program is a State optional eligibility group under the Medical Assistance Program. As of January 1996, 35 states (including Iowa) operated a Medically Needy Program. The allowable income level for the 35 participating states ranges from \$3,000 (Tennessee) to \$12,980 (Massachusetts). Iowa's income level is \$6,792.

CURRENT SITUATION

Medically Needy individuals fall into two broad categories: those required to meet spenddown requirements and those who meet spenddown requirements at the time of application. If an individual's income and resources exceed the Medically Needy Income Level, they are required to spend down their income to the specified income level prior to receiving a Medical Assistance Program card. Spenddown is the process of paying medical expenses out of the individual's personal funds until reaching Medically Needy Income Level.

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Spenddown is analogous to a deductible amount under an insurance policy. If their income is equal to or below the Medically Needy Income Level, they are eligible to receive Medical Assistance Program benefits immediately.

Individuals can be in one of three groups for Medically Needy coverage. The first group contains individuals who are Supplemental Security Income (SSI) eligible individuals (aged, blind, or disabled). This group is certified for twelve months coverage at a single time. The second group includes Family Investment Program Medically Needy recipients who meet spenddown requirements and they are certified for a six-month period. The final group, those having spenddown requirements, are eligible for two months.

The total number of Medically Needy recipients in Iowa as of June 1996, was 6,215. Of this total, approximately 1,277 are required to meet spenddown requirements to be certified for a two-month period. The remainder (4,938) are either in the six- or twelve-month group.

The Medically Needy Income Level is tied to the Family Investment Program benefit level. Federal regulations specify that the Medically Needy Income Level may not exceed 133.0% of the Family Investment Program benefit level for the same size family. In Iowa, the Family Investment Program benefit level is \$5,112 yearly (\$426 monthly) for a family of three. This results in a Medically Needy Income Level of \$6,792 yearly (\$566 monthly) for same size family.

Under current Medical Assistance Program federal regulations, the reimbursement for services is paid to a provider and not the individual. If the individual has paid for the product or service at the time the service or product is provided, they may not receive reimbursement by the Medical Assistance Program. If an individual is unsure about eligibility for the Medically Needy Program, rather than paying for a prescription (for example), the individual must make an arrangement with the pharmacy to defer billing on the product until eligibility for the Medically Needy Program is determined. This places an unequal burden on potential Medically Needy recipients. The individual must attempt to make arrangements with providers of services. However, not all providers will defer billing and not all customers of a single provider are treated the same with respect to billing deferment.

ALTERNATIVES

The DHS has implemented two streamlining efforts to simplify the spenddown process. First, the DHS has implemented a process to obtain client authorization so the DHS can answer questions from providers about an individual's spenddown amount. This process allows providers to determine whether to collect from clients or the Medical Assistance Program. Second, the DHS is moving forward with using the Local Area Network (LAN) to reduce processing days for the Medical Expense Verification form required by the federal government. Both of these initiatives were implemented using existing departmental resources.

The FY 1996 DHS Appropriations Bill (SF 462) contained the following intent language:

“The department shall develop strategies to address administrative and provider concerns associated with discretionary medical assistance provided to individuals and families pursuant to section 249A.3, subsection 4, and the provisions relating to the expenditure of income to a level which qualifies the individual or family as eligible for participation in the medical assistance program. The department shall submit a report regarding the strategies developed to the general assembly on or before November 30, 1995.”

Three alternatives resulted from this report:

- Contract for part of the Medical Expense Verification / Medically Needy Spenddown Control Process. The contractor would be responsible for tracking medical expenses during the certification period to meet spenddown requirements. This alternative might reduce the time necessary to receive a Medical Assistance Program eligibility card for individuals with a spenddown requirement.
- Implement a pay-in option allowing the client to pay the entire amount to the DHS at one time rather than using medical expenses incurred over the certification period. Once the spenddown amount is paid to the DHS, the Medical Assistance Program cards would be issued immediately. If all funds paid to the DHS to meet spenddown requirements were not used, a method of accounting for and reimbursing funds to the client would have to be implemented.
- Provide traditional Medical Assistance Program eligibility for the SSI-related Sixth Omnibus Budget Reconciliation Act (SOBRA) group at 100.0% of the federal poverty level. This would have the advantage of eliminating spenddown and paperwork requirements for this group but would result in significant cost increases.

The first two options are relatively inexpensive. The table below lists the expected FY 1997 and FY 1998 costs of these options.

	FY 1997			FY 1998		
	General Fund	Federal Funds	Total	General Fund	Federal Funds	Total
Pay In to DHS	\$ 38,220	\$ 37,320	\$ 75,540	\$ 32,823	\$ 32,822	\$ 65,645
Contract Out Administration	\$ 51,375	\$ 51,375	\$ 102,750	\$ 36,365	\$ 36,365	\$ 72,730

The third alternative would extend regular Medical Assistance Program coverage to the SSI-SOBRA eligibles and Qualified Medicare Beneficiaries (QMB) (a total of 15,000 recipients) whose income does not exceed 100.0% of the federal poverty level and whose resources do not exceed \$10,000. This would raise the allowable income from \$566 monthly (\$6,792 yearly) to \$1,082 monthly (\$12,900 yearly). The resource limitation would remain at the current level of \$10,000.

As the table below illustrates, the DHS estimates that extending eligibility to both Medically Needy and Qualified Medicare Beneficiaries would result in a \$4.2 million cost to the General Fund in FY 1997 and \$5.3 million in FY 1998. The rationale for including the Qualified Medicare Beneficiaries with the Medically Needy is both groups would fall under the 100.0% of poverty level. In the absence of a federal waiver, both groups would receive coverage. The Qualified Medicare Beneficiaries would receive additional services (prescribed drugs, etc.) not currently available.

	FY 1997			FY 1998		
	General Fund	Federal Funds	Total	General Fund	Federal Funds	Total
Medically Needy	\$ 1,303,903	\$ 2,245,097	\$ 3,549,000	\$ 1,323,191	\$ 2,278,309	\$ 3,601,500
Qualified Medicare Beneficiaries	\$ 2,882,055	\$ 4,962,405	\$ 7,844,460	\$ 3,967,000	\$ 7,100,500	\$ 11,067,500

The increased cost is due to two factors. First, Medically Needy individuals would no longer need to meet spenddown requirements, so the funds currently used to meet spenddown would now be paid by the Medical Assistance Program. Second, by extending services to Qualified Medicare

Beneficiaries (QMB), those individuals would receive the full Medical Assistance Program aid package.

Additional options which have been discussed include extending the period from two months for those requiring spenddown to three or six months. Extending the period for which individuals are covered would result in some simplification for participants, but would make it more difficult to qualify. Individuals with a one-time medical condition would have a more difficult time qualifying because they would have a higher spenddown amount than they would under the current two-month system. For example, if the two-month eligibility system was extended to four months, under current federal regulations the spenddown amount would double. However, paperwork simplification would be of primary benefit to those in the two-month group who must continually meet spenddown requirements.

Administrative savings due to any type of simplification would be minimal, at best. For example, Iowa has approximately 87,000 Family Investment Program recipients and over 229,000 Medical Assistance recipients. The reduction in time spent by caseworkers on the qualification process for 1,277 individuals six times yearly is not likely to result in significant savings.

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