

# **Section A: General Overview of Medicaid, Home and Community Based Services Waivers, and Indiana Long-Term Care**

After reading this section you will:

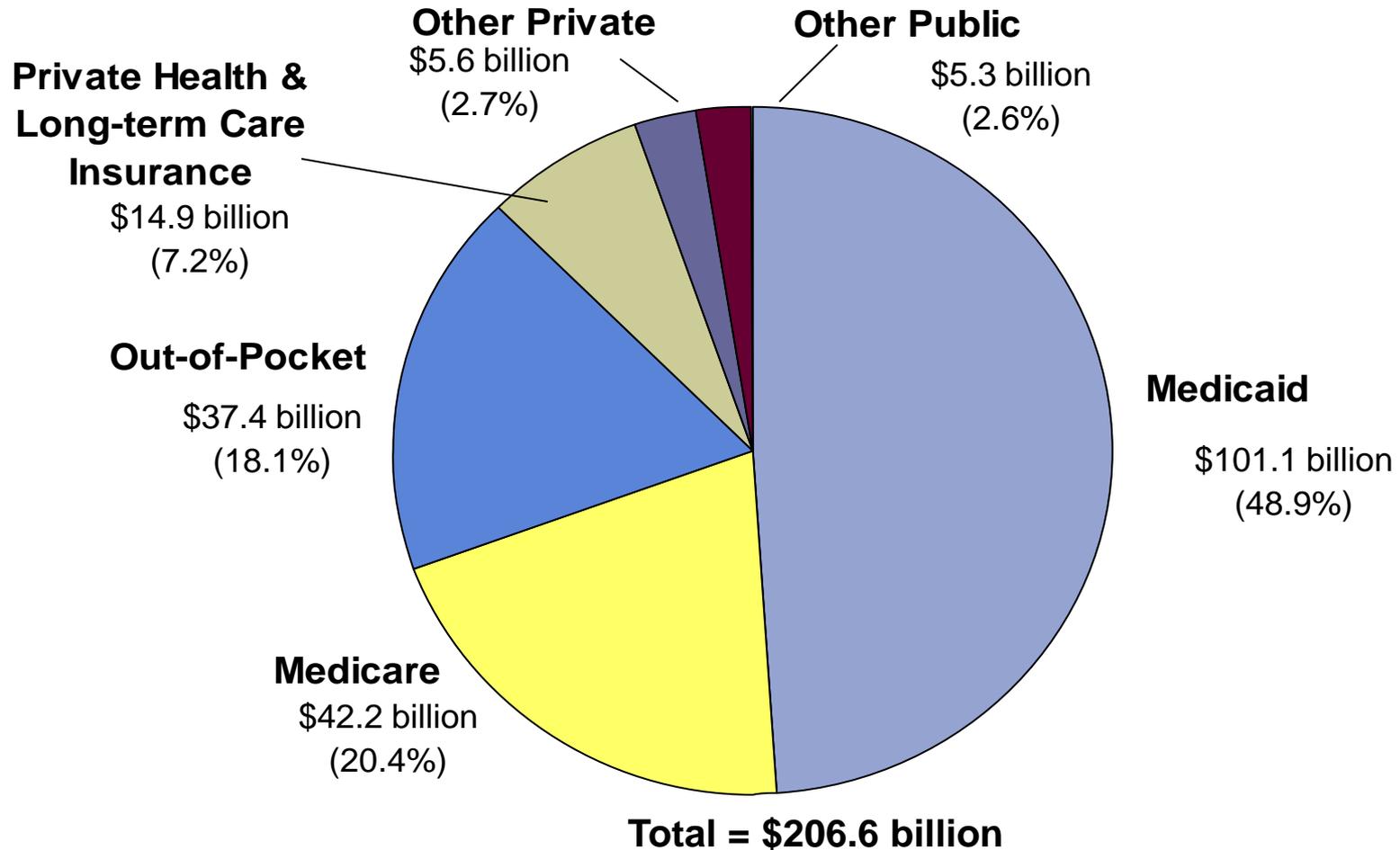
- Understand the Basics of Medicaid
- Identify Indiana Medicaid Programs
- Understand the Goals of the Waiver Program
- Identify DA Long Term Care Initiatives

# What is Medicaid

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- What is Medicaid? Established in 1965, Medicaid is the nation's publicly financed health coverage program for low-income individuals.
- It is operated as more than 50 separate programs – in each state, DC and U.S. territories. Each with its own policies and procedures. No two states have exactly the same way of doing business. They decide who they will cover, what services are offered, how individuals enroll in the program and other day to day operations. This is called the “State Plan.” The State Plan must be approved by the federal government.
- Medicaid is the single largest source of long-term care coverage in the U.S.

# National Spending for Long-Term Care by Payer, 2005



NOTE: Components may not sum due to totals due to rounding.

SOURCE: H. Komisar and L. Thompson, *National Spending for Long-Term Care* (Washington, DC: Georgetown University Long-Term Care Financing Project, February 2007).

# Spending continued

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- The previous slide shows how the Medicaid program paid for over \$100 Billion in long term care costs in 2005. This was just shy of 50% of all LTC costs. The second largest payer was Medicare with 20% of the total funding.
- Together, Medicaid and Medicare finance the majority (69.3%) of long-term care. Most of this is in nursing facility costs.

# What is Medicaid

## ■ **State Plan Services**

- State Medicaid programs must cover certain “mandatory services” as required by federal law.
  - Some Mandatory services include: EPSDT services, pregnancy related services and laboratory and x-ray services.
- States can choose to cover “optional services.”
  - Indiana has chosen to cover Hospice care, Home Health Care, Dental and many other optional services.

## ■ **State plan services of special interest to HCBS waiver enrollees**

- Nursing facility services
- Home health care
- Personal care
- Hospice

# What is Medicaid

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- All states have a “state plan” that is approved by the federal government. The state plan lists what services are available and specific financial and medical eligibility requirements.
- Services on the state plan are available to all people who qualify to take part in the state Medicaid program. Some of these services are federally mandated. We’ve listed just a few of the services that are mandatory. Other services are optional and the state has chosen to cover them. We’ve listed just a few of the optional services Indiana covers.

# What is Medicaid

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- Medicaid Provides Health Coverage for individuals in the following Aide Categories:
  - families,
  - children,
  - pregnant women,
  - aged, blind, and disabled

# Medicaid Eligibility Codes

<b>Code</b>	<b>Category</b>
MA A	Aged - full coverage
MA B	Blind - full coverage
MA D	Disabled – full coverage
MADW	Disabled – working individual
MA R	Room and Board Assistance (RBA) – full coverage
MA 9	Children age 1-18 – full coverage
MA L	Qualified Medicare Beneficiary (QMB) – limited coverage

\*\*\*This is a partial list of Medicaid codes. There is a full list in your handout packet.

# What is Medicaid

- Individuals that are eligible for Medicaid services are assigned to a specific program based on their age, income, family situation, diagnosis and medical needs.
  - **Hoosier Healthwise** – Serves Children, low-income families, and pregnant women. Includes CHIP.
  - **Care Select** – Serves Aged, Blind, Disabled, including Waiver participants. Replacing Medicaid Select.
  - **Traditional Medicaid** – serves the Medicaid population that is excluded from or waiting to be assigned to one of the other health programs, includes dual eligibles, spend-down recipients, and Breast and Cervical Cancer Treatment recipients.
  - **HIP** – New program that serves adults 19-64 who have no other source of insurance. Waiver participants are not eligible for the HIP plan.

# Managed Care vs. Fee for Service

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- **Managed Care** – is the practice of contracting with a managed care organization (MCO) (Anthem, MDwise, etc) to provide medical services. This can be done as:
  - Risk-based managed care – where the MCO is paid a fixed monthly fee per member.
  - Primary Care Case Management – a provider is responsible for acting as a “gatekeeper” to approve and monitor the provision of services.
- **Fee-for-Service** - The traditional healthcare payment system, under which physicians and other providers receive a payment for each unit of service they provide.
  - Indiana’s HCBS Waivers are provided on a fee for service basis.

# Managed Care vs. Fee for Service

- Medicaid in Indiana acts as the payer of health care for eligible individuals. The Medicaid staff do not actually see or treat patients. Medicaid does not employ hundreds or thousands of Doctors to provide care. Medicaid acts as the payer for health care for individuals on Medicaid. To do this, Indiana contracts with many providers of health care to provide services to the members. Indiana Medicaid utilizes both managed care and fee for service plans to provide medical care.
- In Managed care, the state has contracted with a large managed care organization to deliver health care services. Individuals sign up with their choice of MCO. In risk based managed care, the MCO receives a set amount of money per month per member. They are then responsible for making sure the member receives services that are part of the plan. The MCO can make a profit off of some individuals who don't seek care in a given month – but may lose money on an individual who utilizes several services in a month.
- In a fee for service system – a service is delivered and Medicaid pays the provider an agreed upon rate. For example, if you go to the Dr. for a simple ear infection, the doctor has agreed to perform that service at the Medicaid rate.

# Prior Authorization

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- Prior Authorization (PA) is an administrative tool that allows Office of Medicaid Policy & Planning to manage utilization, ensuring that appropriate services are provided to appropriate individuals.
- If a service requires PA, you must get prior approval before an individual can receive that service.
- PA is currently contracted out to ADVANTAGE Health Solutions and MDwise.

# What Are Waivers

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- There are 3 types of waivers
  - 1115 Research and Demonstration Projects: Projects that test policy innovations likely to further the objectives of the Medicaid program.
  - 1915(b) Managed Care/Freedom of Choice Waivers: Allow states to implement managed care delivery systems or otherwise limit individuals choice of provider under Medicaid.
  - 1915(c) Home and Community Based Services Waivers: Waive Medicaid provisions in order to allow long-term care services to be delivered in community settings.

# What Are Waivers

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- HCBS waivers are the Medicaid alternative to providing comprehensive long-term services in institutional settings.
- Medicaid Waivers are designed to provide services to people who would have traditionally been served in an institution – such as a nursing facility or a State DD hospital. The “waiver” services are designed to allow an individual to live in a community setting. This could be their own home or apartment, an assisted living facility or Adult Foster Care.
- A Medicaid waiver is a set of services that Medicaid can deliver to a set population of people. The states have flexibility in what services they offer and to what population.

# What are Waivers

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- States can design waiver programs to meet the needs of specific populations (like the Aging population). But they must meet several federal requirements – some of the general requirements that they must meet include:
  - Demonstrating that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution. This cost effectiveness is on the aggregate level. It may cost more for a particular individual to be served in the community as long as the average for all served in the community is less than the institutional cost would be.
  - Ensuring that measures will be taken to protect the health and welfare of consumers
  - Providing adequate and reasonable provider standards to meet the needs of the target population.
  - Ensuring that services are provided in accordance with the plan of care.

# What are Waivers

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- What is being waived? Certain Federal Guidelines that the State Medicaid Program would otherwise be required to follow:
  - Comparability – allowing states to make waiver services available to certain populations
  - Statewideness – allowing states to target certain areas
  - Income Rules – allowing states to provide services to persons who would otherwise only be eligible for nursing facility care.
  
- What is not waived?
  - Freedom of choice of provider
  - Choice between institutional care and HCBS waiver

# What are Waivers

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- What are the goals of HCBS Waivers?
  - Provide an alternative to nursing facility admission for adults and individuals of all ages with a disability.
  - Provide services to supplement informal supports for people who would require care in a nursing facility if the waiver were not available.
  - Help people stay in their own homes or to live in an apartment, an assisted living facility, or adult foster care.
  - Help an individual move out of a nursing facility and back into a community setting.

# What Are Waivers

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- **Home and Community Based Services (HCBS)**

Waivers are the emphasis of our training. They include:

- The Aged and Disabled Waiver (A&D)
- The Traumatic Brain Injury Waiver (TBI)
- The Developmental Disabilities Waiver (DD)
- The Support Services Waiver (SSW)
- The Autism Waiver (AU)

# Federal Laws, Rules and Guidelines

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- Federal Laws, Rules and Guidelines that oversee the Division of Aging, The Office of Medicaid Policy and Planning and their operation of the Medicaid waivers come from:
  - Title XIX of the Social Security Act
  - Title 42 of the Code of Federal Regulation
  - State Medicaid Manual

# Non-Medicaid Supports & Funding Options

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- It is important to think about all of the available services, formal and informal, as you design a plan of care for an individual.
  
- The next few slides highlight several non-Medicaid supports that may be available:
  - Medicare
  - Vocational Rehabilitation Services
  - Private Insurance
  - CHOICE
  - Title III of the Older American's Act
  - Title III-E National Family Caregiver Program
  - Social Service Block Grant (SSBG)

# Non-Medicaid Supports & Funding

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- You will often hear Medicaid called the “payer of last resort” this is an important concept to keep in mind when you are designing services for an individual. There is a set amount of Medicaid waiver money available and we must work to utilize that funding in the best possible way.
- Waiver services are designed to complement and supplement the services that are available through the Medicaid State Plan, other federal programs, and informal supports.
- You must look at each individual and their entire situation. What do they really need, what can they get from another source? Do they need Waiver funds to provide two meals a day or do they live with a family member who can provide dinner each day?
- We are going to highlight several non-Medicaid supports that may be available to an individual and should be used to fund needed services before the waiver.

# Non-Medicaid Supports: Medicare

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- Medicare – A federal health insurance program that covers 37 million elderly Americans and 7 million non-elderly individuals with permanent disabilities.
- About 1 in 6 Medicare beneficiaries, based on their low income, are also eligible for Medicaid. They are “dual eligible.”
- Dual eligible individuals have much lower income and tend to have increased health needs compared to other Medicare enrollees.
- The Medicaid program supplements Medicare coverage by providing services and supplies that are available under the State plan. Services that are covered by both Medicare and Medicaid will be paid first by Medicare.

# Non-Medicaid Supports: VR

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- Vocational Rehabilitation Services (VR) provides services needed by eligible individuals with disabilities to prepare for, enter, engage in and retain employment.

## **Persons eligible for VR services include:**

- persons who have a physical or mental impairment;
- persons whose impairment constitutes or results in a substantial impediment to employment;
- persons who can benefit in terms of an employment outcome from the provision of vocational rehabilitation services and
- persons who require services to help prepare for gainful employment

# VR Continued

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- VR services can include:
  - Vehicle modifications/environmental modification/adaptive equipment
  - Education
  - Vocational counseling and guidance
  - Training – including vocational school, college, or on the job training.
  - Assistive devices and technology
  
- VR can provide a little or a lot of help for an individual. They can widen a door and add a ramp to allow an individual to leave their home and get to work. Or they can help provide for a 4 year college degree.

# Non-Medicaid Supports: Third Party Liability

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- The Medicaid program, by law, is the payer of last resort; that is, all other available third party resources must meet their legal obligations to pay claims before the Medicaid program pays.
- Third party resources may include private health insurance, Medicare, employment related health insurance, court ordered health insurance, court judgments or settlements, workers compensation, long-term care insurance etc.

# Non-Medicaid Supports: CHOICE

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- CHOICE- Community and Home Options to Institutional Care for the Elderly and Disabled
  - 100% State Funds
  - Can provide services to individuals who are not Medicaid eligible but do need assistance. CHOICE services are for people of all income levels. There are cost share provisions for those with greater incomes.
  - Must first exhaust all other formal payment sources for funding services in the home.
  - Services available: home-delivered meals, personal care, care management, respite care, transportation, minor home modifications, adaptive aids and devices.

# Non-Medicaid Supports: Title III of the Older Americans Act

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- Federal funding under the Older Americans Act
  - Services for people 60 years of age and older
  - No income restrictions
  - Target Population: Those with greatest economic and social need - low income and minorities, rural areas
  - Services Available: In Home Services (Homemaker, ADS, Attendant Care), Information and Assistance, Congregate Meals, Home Delivered meals, Legal Services, Transportation.

# Non-Medicaid Supports:

## Title III-E National Caregiver Support Program

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- Federal funding program that started in 2000. It is Administered through the AAA/Aging and Disability Resource Centers(ADRC).
  - The main goal is to assist family caregivers
  - Priority is given to those caring for individuals with dementia, those caring for an adult disabled child, and grandparents or relative caregivers 55 and older caring for children
- Services Available: Providing information to caregivers; Assistance/Training for caregivers; Respite Services; Organization of support groups/individual counseling; Supplemental services that complement the care provided by the caregiver.

# Non-Medicaid Supports: Social Service Block Grant (SSBG)

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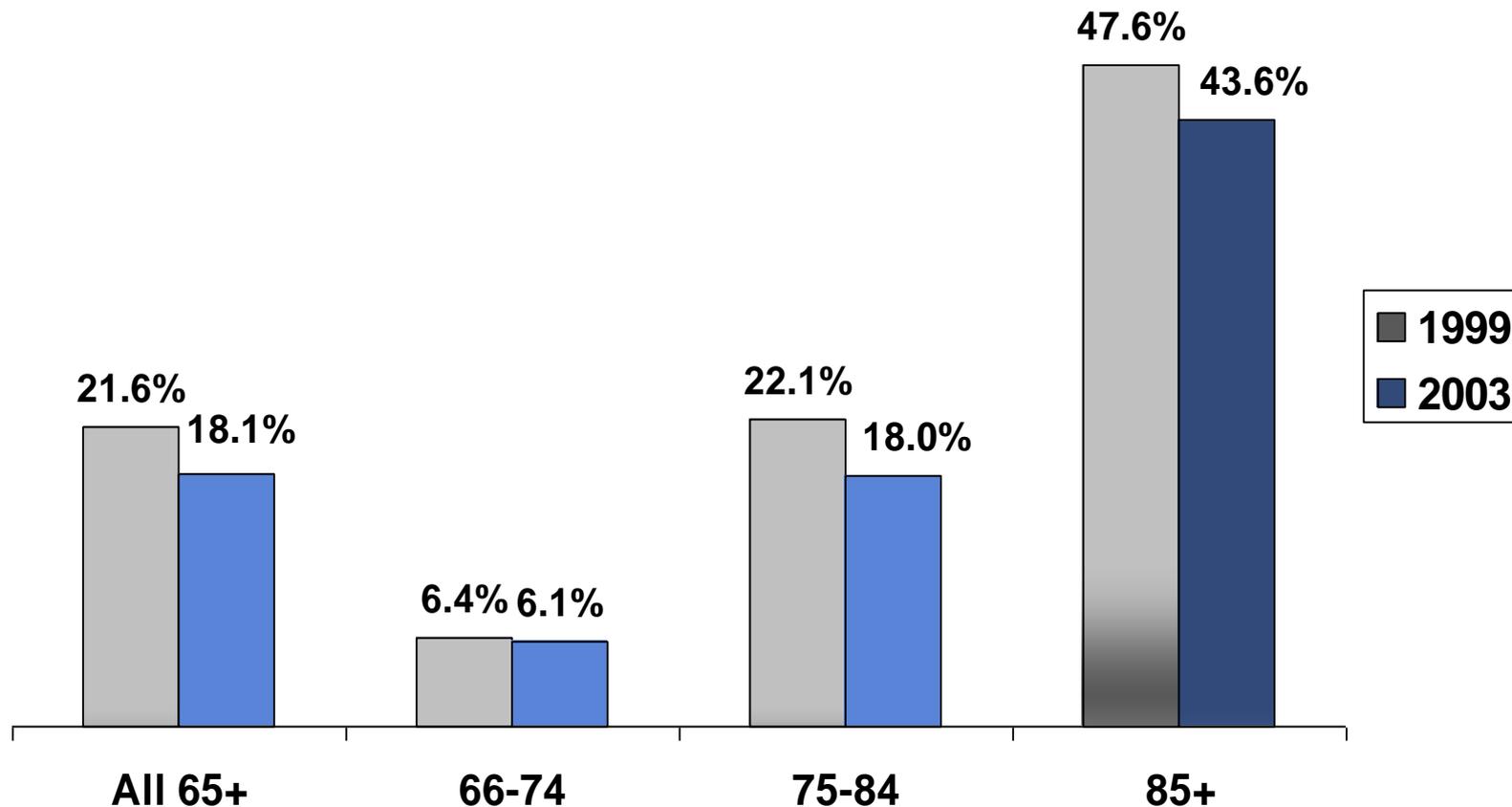
- Federal Funding that provides service to people of any age with a demonstrated need.
  - Minorities and economically disadvantaged people are targeted
  - Services Available: Case management, Personal Care, homemaker, other services vary by AAA/ADRC.

# Indiana Long Term Care Philosophy

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The Division of Aging and OMPP are working to improve all Long Term Care options in Indiana. The Division of Aging wants to offer a flexible array of community based service options that allow an individual to live in their own home, an adult foster care setting, assisted living, an apartment, a nursing facility or with a relative. The focus is on the individual making the best choice for them and their situation, rather than being driven by the funding that is available.

# Percent of Medicaid Beneficiaries Age 65+ with Nursing Home Use



SOURCE: Kaiser Commission on Medicaid and the Uninsured. KCMU estimates based on analysis of the 1999 and 2003 Medicare Current Beneficiary Survey, Kasper and O'Malley 2007.

- The previous slide shows the national averages for nursing home use, as you see from 1999 – 2003 there were declines in the number of Individuals that are choosing to go into a nursing home. On a national level there are several factors that are leading to this reduction including:
  - [Decreasing rates of disability and increasing prosperity among older Americans;](#)
  - [Advances in medicine and health care treatment;](#)
  - [Development of alternatives to nursing homes such as assisted living and home care;](#)
  - [Increased availability of long-term care insurance allowing individuals more options for how they receive care;](#)
  - [State efforts to increase home and community based services and to improve care management.](#)
  
- The Division of Aging is working every day to improve the community treatment options that are available to the elderly and disabled with the goal of providing everyone with a choice of where to live.

[1] Alecxih, Lisa; *Nursing Home Use by “Oldest Old” Sharply Declines*; Presentation to the National Press Club; November 21, 2006.

[2] Alecxih, Lisa; *1995-2005 Medicaid LTC Trends for Elderly and Individuals Under Age 65 with Physical Disabilities*; 2007 CMS New Freedom Initiative Conference; Accessed at [http://www.governor.wa.gov/lctcf/reports/050207/5-2-07\\_trends.pdf](http://www.governor.wa.gov/lctcf/reports/050207/5-2-07_trends.pdf).

[3] Georgetown University; January 2007.

# Division of Aging Initiatives

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- There are several initiatives that will allow older adults and individuals with a disability at any age to choose the services that are right for them and their family - Including:
  - **Aging and Disability Resource Centers**
  - **Options Counseling**
  - **Money Follows The Person Grant**
  - **Expand Community Based Settings**

# Aging and Disability Resource Centers

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- Indiana received a Federal Grant to help establish our Aging and Disability Resource Center (ADRC) system and all 16 AAAs are now ADRCs.
- The National ADRC Goal is “to have Aging and Disability Resource Centers in every community serving as highly visible and trusted places where people of all incomes and ages can turn for information on the full range of long-term support options and a single point of entry for access to public long-term support programs and benefits.”

# ADRC

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- An ADRC is a single entry point to serve all individuals in the community, those that are Medicare Or Medicaid, those that can pay for their own services, those that are low income.
- The ADRC should be the one place that all people in a community think of when they are aging, or looking after an aging parent.
- The ADRC will be able to refer individuals to all types of services and make people aware of their options.

# Options Counseling

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- Options counseling makes consumers aware of all the available services that they may be eligible to receive. Many older individuals and individuals of any age with a disability and their families are not aware of the community based services that are available.
- AAAs/ADRCs are responsible for providing Options Counseling to anyone who is looking for long term care services.
- Administration on Aging defines Options Counseling as “an interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer’s needs, preferences, values, and individual circumstances.”

# Money Follows the Person Grant

- MFP Grant from the Centers for Medicare and Medicaid Services was awarded to promote a strategic approach to implementing a system to transition individuals from institutional settings to qualified community based settings.
- MFP will transition individuals from a nursing facility into a community setting if they:
  - Have been in a nursing facility for more than 3 months
  - Have indicated that they would like to leave the nursing facility
  - Are Medicaid eligible.
- A transition team made up of a nurse and a transition specialist, will work with MFP recipients and facilitate transitions.
- Transition teams will work together to identify the basic social, medical, nutritional, and support networks necessary for the MFP participant to thrive in the community.
- Advantage Health Solutions will be employing the transition teams.

# Expanding Community Based Resources

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DA is working to build capacity in community based resources. This includes an array of housing and service options that are available.

- **Assisted Living:** A licensed residential care facility that provides the level of services needed by that individual. Including meal plans, social activities, and an on-call nurse.
- **Adult Foster Care:** Allows an individual to live full time in a private home where they have a separate bedroom, home-cooked meals, and appropriate social activities.
- **Adult Day Services:** Structured, comprehensive program providing health, social and related support services in a protective setting. Maximum of 10 hrs per day.

# Additional Resources

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- FSSA Aging Page

<http://www.in.gov/fssa/da/index.htm>

- IHCP - OMPP Medicaid Page

[www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)

- Medicaid Provider Manual

[www.indianamedicaid.com/ihcp/Manuals/Other/HCBS%20Waiver%20Provider%20Manual%20%202-13-2007.pdf](http://www.indianamedicaid.com/ihcp/Manuals/Other/HCBS%20Waiver%20Provider%20Manual%20%202-13-2007.pdf)

- Centers for Medicare and Medicaid Services

<http://www.cms.hhs.gov/home/medicaid.asp>