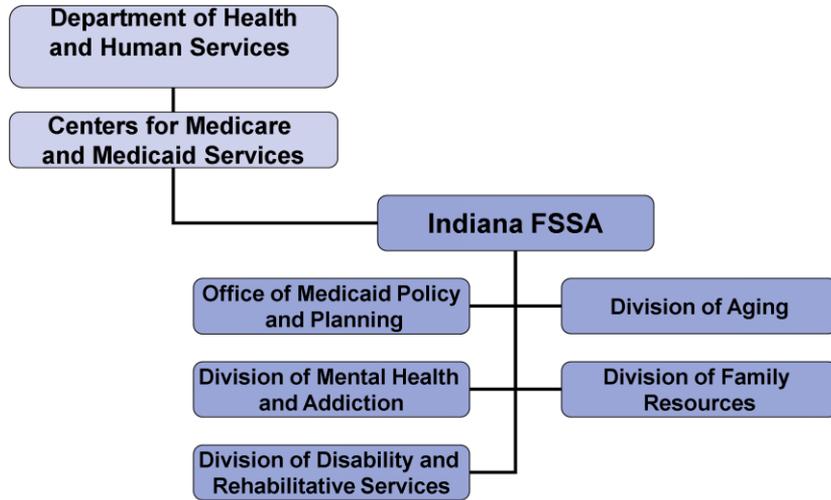


Section B: Indiana's A&D and TBI Waiver Administration, Eligibility, Required Documents, Available Services, Providers

After this session you will be able to:

- Identify different levels of federal and state government and their role in waiver administration
- Understand the eligibility process
- Identify waiver services
- Identify provider requirements

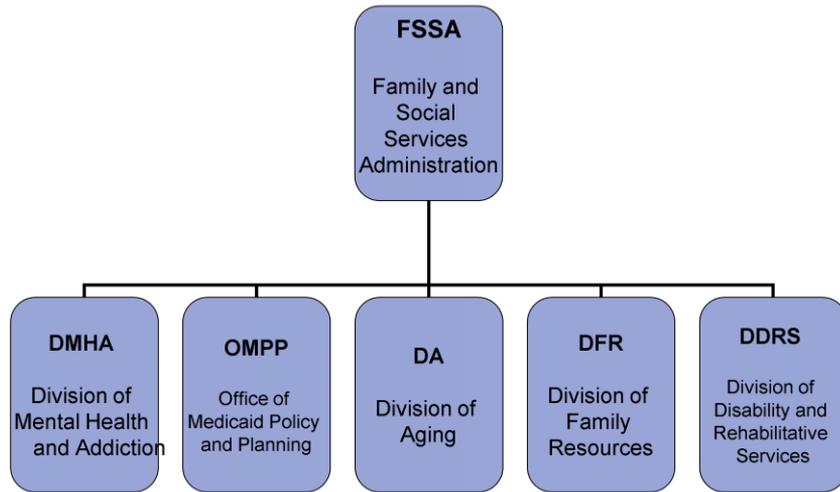
Waiver Administration



Waiver Administration

- The State Administers the Medicaid program within federal guidelines.
- Each state can design the coverage, programs and services that they want to operate in their state. They must do so within the broad guidelines set out by the Federal Government and with their approval. So each state has some differences in their Medicaid programs, including what services are offered, eligibility guidelines, and how the provider and billing systems are structured.
- In Indiana, the Family and Social Services Administration is the agency that operates many of the social services in the state, including the Medicaid program. FSSA is made up of 5 divisions. The Office of Medicaid Policy and Planning (OMPP), The Division of Aging, The Division of Mental Health and Addiction, The Division of Family Resources, and The Division of Disability and Rehabilitative Services.
- The Centers for Medicare and Medicaid Services (CMS) - part of the Department of Health and Human Services is the federal entity that regulates State Medicaid programs.

FSSA Organizational Chart



FSSA Organizational Chart

- **FSSA** – is the umbrella Agency that oversees the state Medicaid program in addition to many of the social services of the state of Indiana. The Agency is made up of 5 divisions, each with it's own programs and population specific priorities. Some of the major programs and responsibilities for each division include:
- **The Division of Aging** – Oversees Nursing Facility Level of Care waivers (A&D and TBI waivers), oversee nursing facility operations, Licensed Residential Care Facilities, RCAP Program, CHOICE, home health care and hospice
- **The Office of Medicaid Policy and Planning** – All Medicaid Waivers, Funding Source for Medicaid Programs, Health Care to 1 in 6 Hoosiers
- **Division of Mental Health and Addiction** – Run 6 State Operated Psychiatric Hospitals, Oversight of Community Mental Health Centers throughout the State. Certify addiction providers throughout the state.
- **Division of Disability and Rehabilitative Services** – Oversight of the ICF/MR Level of Care waivers (DD, SSW, and Autism waivers), Vocational Rehabilitation Services, First Steps (for kids 0-3)
- **Division of Family Resources** – Medicaid Eligibility, TANF, Food Stamps

Waiver Administration - FSSA Roles

- Each FSSA Division has a distinct role in Waiver Administration. Some of these things include:
 - OMPP – Reviews, approves and submits waiver documents to CMS
 - DA & OMPP – Define policies for the A&D and TBI waiver
 - DDRS & OMPP – Define policies for the DD, Autism and Support Services waivers.
 - DFR – Accepts Medicaid applications, determines financial eligibility and enrolls people in Medicaid.
 - Modernization Project – Changing the enrollment and intake process by contracting with a private entity.
 - Is currently being utilized in several areas of the state.

Waiver Administration – FSSA roles

- The Divisions of FSSA work together to operate the Medicaid Waiver program. Within FSSA, divisions have distinct roles but must work closely together.
- OMPP is responsible for drafting and submitting the Waiver documents to CMS. OMPP and the Division of Aging work together to define policies for each waiver – such as who is eligible to receive services, what services will be offered through the waiver, who can be a service provider.
- DFR actually accepts the Medicaid application and determines financial eligibility.

Waiver Administration - Indiana Laws, Rules, Policies, Procedures

- OMPP and DA must follow applicable state laws and rules.
 - Indiana Code (IC)
 - IC 12-10
 - Indiana Administrative Code (IAC)
 - 455 IAC 1.2

- OMPP and DA also set their own policies and procedures
 - HCBS Waiver Provider Manual
 - Waiver approved by CMS

Waiver Administration - Indiana Laws, Rules, Policies, Procedures

- In addition to federal regulations and law, the Medicaid program and the Division of Aging must follow the laws and rules set out at the State level. This includes the Indiana Code and Indiana Administrative Code. Most of the regulations that apply specifically to the Division of Aging can be found at IC 12-10 and 455 IAC 1.2.
- OMPP and DA both also establish policies and procedures for program operation. The Home and Community Based Services Waiver Provider Manual is a great resource for documentation on the waiver program.
- Waiver approved by CMS

Eligibility

- Individuals must meet Medical and Financial Eligibility requirements.

	A & D Waiver	TBI Waiver
Financial Eligibility	<ul style="list-style-type: none"> ■ 300% of SSI ■ Parental income and resources disregarded for children under 18 (Senate Bill 30) ■ Spousal impoverishment protections similar to those for nursing homes 	<ul style="list-style-type: none"> ■ 300% of SSI ■ Parental income and resources disregarded for children under 18 (Senate Bill 30) ■ Spousal impoverishment protections similar to those for nursing homes
Medical Eligibility	<ul style="list-style-type: none"> ■ Nursing Facility Level of Care 	<ul style="list-style-type: none"> ■ Diagnosis of Traumatic Brain Injury ■ Nursing Facility Level of Care or ICF/MR

Eligibility

- Individuals must meet both financial and Medical eligibility requirements to be served by Medicaid.
- Income eligibility levels for individuals on the TBI and A & D waiver can be up to 3 times the maximum SSI benefits.
- For other Medicaid services, the Federal Poverty Level (FPL) is used for determining eligibility. The FPL and SSI benefits numbers change each year so you should keep aware of these calculations each year.
- To be eligible for the A & D waiver you must meet Nursing Facility Level of care. That means you must have difficulty with 3 or more ADLs or Activities of Daily Living.

Eligibility Cont.

- For the TBI waiver you must meet NF or ICF/MR level of care and have a diagnosis of a traumatic brain injury. Indiana defines a traumatic brain injury as a trauma that has occurred as a closed or open head injury by an external event that results in damage to brain tissue, with or without injury to other body organs. Examples of external agents are: mechanical; or events that result in interference with vital functions. Traumatic brain injury means a sudden insult or damage to brain function, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability not including birth trauma related injury.

Financial Eligibility

- Financial Eligibility is determined by the Division of Family Resources.
- Financial Eligibility Considerations:
 - **Special Income Group** – 300% SSI
 - **Spend-Down** – Allows someone to spend enough of their resources on medical expenses each month to become financially eligible for Medicaid.
 - **Spousal Impoverishment Protection** – protects some assets and income for the spouse of an individual on the waiver.

Financial Eligibility: 300% of SSI

	100% of SSI	300% of SSI (SSI X 3)
1 Person	\$698	\$2094 Income limit
Married Couple	\$1048	\$3144 Income Limit

*These figures are accurate as of January 2012

- The 300% SSI special income groups allows individuals who have an income that falls at or below 3 times the SSI income payment. The table above illustrates these limits. However, if the person receives more than 300% of the SSI amount, they do not qualify and their spend-down is figured on the basic SSI amount.
- For example: if they receive \$2097 (\$3 more than 300% of SSI), they would be excluded from this provision and the spend-down goes back to the 100% level.

Financial Eligibility: Spend-Down

- Provision that allows someone to qualify for Medicaid assistance when his/her income (and in a few situations, resources) exceed the Medicaid eligibility standard.
 - “Spend-down” is the amount that the individual must incur in medical expenses each month on medical care before Medicaid pays for services.
 - Medical expenses that are paid by Medicare or other health insurance are not allowed to count toward the individual’s spend-down.

Financial Eligibility: Spend-Down

- How does it work?
 - The individual receives medical services during the month and is billed for his/her spend-down amount by the provider after the provider is notified by Medicaid of the amount that has been credited for spend-down and can therefore be billed to the individual.
- Exception to this is a point-of-sale provider, like a pharmacy, who is told right away any amount the individual owes for spend-down.

Financial Eligibility: Spend-Down Example

- Susan is found to qualify for Medicaid with a spend-down of \$154 a month.
- Susan goes to the pharmacy. Because it is a pharmacy, which is a point of sale service, she must pay for the medications at the time of purchase. The cost of her medications is \$74 which she pays to the pharmacy and that \$74 goes towards her spend-down amount.

Medical Eligibility

- What is Level of Care (LOC)? – The minimum needs that an individual must have to be considered eligible for the waiver.
 - For the A&D waiver LOC is Nursing Facility LOC. TBI may be Nursing Facility or ICF/MR due to a TBI.

Medical Eligibility

- Level of Care – to be medically eligible for the waiver program an individual must meet the required “Level of Care” this is the term used to describe the medical needs of an individual. Someone must have a certain level of medical need to meet “level of care.” Different Medicaid waivers and Medicaid programs can have different Level of Care specifications.
- LOC is determined by the AAA based on an assessment and physician exam and recommendation of HCBS services on the 450B form. The Case manager will have the form for the physician.
 - For the A & D waiver the level of care is Nursing Facility Level of Care, meaning that the person would be at risk of being placed in a nursing facility without the services provided by the waiver.
 - For the TBI waiver the LOC is also Nursing Facility Level of Care or ICF/MR, meaning that the person would be at risk of being placed in a nursing facility without the services provided by the waiver. LOC is determined by the Division of Aging based on a physical examination and physician recommendation of HCBS services on the 450B form. The Case manager will have the form for the physician.

Required Documents

- Documentation is critical. All individuals must have the correct forms including:
 - 450B – Physicians Certification for Long Term Care
 - Form 11
 - Eligibility Screen
 - Freedom of Choice form
 - Plan of Care form

- Detailed documentation requirements will be covered during the case manager orientation in person session.

Available Services – A&D Waiver

- Case Management
- Homemaker
- Respite Care
- Adult Day Services
- Environmental Modifications
- Transportation
- Specialized Medical Equipment and Supplies
- Vehicle Modifications
- Health Care Coordination
- Personal Emergency Response System
- Attendant Care, including self-directed attendant care
- Adult Foster Care
- Assisted Living
- Home Delivered meals
- Nutritional Supplements
- Pest Control
- Community Transition Services

Available Services – TBI Waiver

- Case Management
- Homemaker
- Home Delivered Meals
- Respite Care
- Adult Foster Care
- Adult Day Services
- Residential Based Habilitation
- Day Habilitation/Structured Day Program
- Supported Employment
- Environmental Modifications
- Health Care Coordination
- Transportation
- Specialized Medical Equipment and Supplies (including vehicle modifications)
- Personal Emergency Response System
- Attendant Care
- Occupational Therapy
- Physical Therapy
- Speech-Language Therapy
- Behavior Management/Behavior Program and Counseling

Available Waiver Services

- Are available to an enrollee based on their medical necessity for each service
- Are subject to any limitations or exclusions
 - The state may establish limits on the amount, duration, and scope of each service.
 - The state may not limit the number of waiver participants who may receive a particular waiver service or deny a needed waiver service due to a lack of funds.

Coordination with State Plan and Other Payers

- CMS requires that Federal Financial Participation (FFP) may not be claimed for services when another third party is legally liable.
 - FFP is often referred to as “match” or “federal matching dollars.”
- This applies to all Medicaid services including waiver services.

Provider Requirements

- All providers must meet the requirements in Indiana Administrative Code (IAC) 455 1.2 regarding:
 - qualifications
 - certification
 - enrollment
 - code of ethics
 - documentation
 - payment

Additional Resources

- **Indiana Code 12-10**

http://www.in.gov/legislative/ic_iac/

- **Indiana Administrative Code 455 IAC 1.2**

http://www.in.gov/legislative/ic_iac/

- **Waiver Manual**

<http://www.indianamedicaid.com/ihcp/Publications/manuals.htm>

- **Waiver Documents**

<http://www.indianamedicaid.com/ihcp/index.asp>