

MEDICAID WAIVERS

The Indiana Plan for Aging in Place

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I have never had a client tell me the client wants to go to a nursing home. Sadly, I use to advise families the only place to obtain services for mom and dad was in a nursing home. Thanks to Governor Daniels, Family & Social Services Administration ("FSSA"), and our legislators, this is no longer true. We now have a variety of waiver services that will allow our clients to stay at home longer with financial assistance from Medicaid. These new waiver services are very important programs for the neediest of our clients.

Medicaid Waivers

Medicaid is a federal entitlement program that is administered in a slightly different manner by each state. Each state is required to provide certain basic Medicaid benefits to eligible individuals. There are optional benefits that states can provide if funds are available to pay for these benefits. Federal law 42 U.S.C. § 1396n(c) permits states to "waive" the requirement to provide services to all eligible individuals for certain optional programs that the state adopts. Waiver services are not an entitlement, so the state can limit the number of people who receive services.

Waiver Programs in Indiana

Indiana now has five specific waiver programs. These programs are:

- Aged and Disabled Waiver
- Autism Waiver
- Traumatic Brain Injury
- Developmentally Disabled Waiver
- Support Services Waiver

This presentation focuses on the requirements for eligibility for the Aged and Disabled Waiver program.

Eligibility Criteria

Eligibility for the Aged and Disabled Waiver Program requires:

1. The person must meet Medicaid resource and income guidelines; AND
2. The person must meet nursing home level of care but for the waiver or other services; AND
3. The cost of providing services to the person must be less than the cost of being in a nursing home.

The State of Indiana has adopted the concept of "Aging in Place." The use of waiver services is a major tool in implementing this concept. The dollars involved in making this happen are incredible. The goal is to take as many people as possible out of "institutions" and allow them to live in a more home-like setting.

Indiana's Aging Reform Initiatives

The Indiana Division of Aging budget is based on its Aging Reform Initiatives. This plan has the following five components.

- Integrate all Home and Community Based Services, Nursing Facilities, and Hospice services into a single, integrated long term care solution and brand this solution as Indiana Options for Long Term Care (OPTIONS).
- Maximize federal financial participation by creating clear and distinct funding streams for Community and Home Options to Institutional Care for

the Elderly and Persons with Disabilities (CHOICE) program and OPTIONS consumers.

- Increase the capacity and supply of non-Nursing Facilities OPTIONS providers by providing rate increases and through the enhancement of available programs.
- Increase the demand for non-Nursing Facilities OPTIONS services through a combination of equalizing financial eligibility requirements and an information campaign designed by a professional public relations firm.
- Achieve the closure of 1,500 licensed, certified, and occupied nursing facility Title XIX beds through a combination of incentives and a direct sales effort to the nursing facility industry that will identify the beds to be closed.

The Application Process

The Goal

A potential waiver member must enroll in the Indiana Health Coverage Program (IHCP). Waiver members may not be enrolled in managed care.

The goal is to have your client obtain an open level of care status in IndianaAIM. IndianaAIM is the Indiana Medicaid Management Information System. This system is maintained by the fiscal agent (Electronic Data Systems).

FSSA also maintains a system for waiver recipients known as INsite. The INsite system stores client eligibility information along with:

- Client cost comparison budget (CCBs)

- Notice of Action (NOAs)
- Level of Care (LOC) information
- Case notes of care managers
- Plan of Care (POC)

Waiver authorization is obtained by the waiver case manager completing the POC/CCB which results in an approved NOA. The NOA details the approved service, the approved provider of service, and the health code for the provider to use in billing. The case manager provides this information to INsite and INsite notifies IndianaAIM.

The Process

The starting point for the waiver program is the initial assessment performed by the local Area Agency on Aging, a list of the AAAs is attached to these materials with phone numbers (Appendix A). When you have a client that may be eligible for waiver services, you should call your local agency and request an assessment. A MEDICAID NUMBER IS NOT REQUIRED WHEN THE ASSESSMENT IS PERFORMED! However, Medicaid must be approved in one of the eligible aid categories (A-Aged, B-Blind, D-Disabled, C-Low Income, or MD- Medworks) before the waiver services can begin.

The assessment must show that your client needs institutionalization in the absence of the waiver and/or other home-based services. The criteria necessary to meet this level of care is outlined in 405 IAC 1-3. The form completed by the AAA representative is called the "Assessment for Combined Case Management." A copy of

this form is attached as Appendix B. You will need to obtain a copy of the completed form in order to properly advocate for your client.

The assessment process also includes completion of the “Physician Certification for Long-Term Care Services”, or as it is more commonly known, Form 450B. The important part of this form for waiver services is the section on the lower page portion entitled "Level of Care Physician Certification." You will want to work with your client's physician to ensure that this form is properly completed when applying for waiver services. A copy of this form is attached as Appendix C. Form 450B gets sent to the local AAA when the applicant is applying for a Medicaid waiver. Again, you will want to retain a copy in your file. The State will review the assessment from the local office, along with the 450B form to determine the date on which level of care is approved. Most level of care assessments are done by the case manager and supervisor at the AAA. If the client has a developmental disability or has mental retardation then a nurse waiver specialist in Indianapolis will make the final determination that an applicant meets nursing home level of care.

The local AAA assigns a case manager to the applicant. The case manager is responsible for:

- Level of care assessment;
- Ongoing coordination with the Division of Family Resources regarding Medicaid eligibility status;
- Plan of Care development;
- Monitoring.

Once the applicant is approved for waiver services, the applicant may keep his or her current case manager or choose an independent, non AAA case manager for ongoing case management.

Whether an applicant elects to enter a nursing home or is going to receive waiver services, the form titled "Statement for Freedom of Choice" should be completed. Also known as Form 46016 (attached as Appendix D) this form is designed to inform people that waiver services are available.

The "Notice of Action" (Form 46015, Appendix E), is used to notify an applicant and all providers about the status of his or her waiver eligibility. This form is important because the receipt of the form starts the 30 days an individual has to appeal an adverse action to an Administrative Law Judge. Once the State generates the Notice of Action, services may be implemented for the applicant.

The "Transmittal for Medicaid Level of Care Eligibility" (Form 46018, Appendix F), is the form that indicates that an applicant is eligible for waiver services and indicates the priority level the applicant has to obtain these services.

Income Rules

A new procedure, called the Special Income Level (SIL), went into effect July 2006. This budget calculation allows the applicant/recipient to have up to three (3) times the SSI maximum. This amount as of January 2007 is \$1,869 per month. If the applicant/recipient's income is above this level, the person may qualify for Medicaid but they would incur a spend down. The Spousal Impoverishment rules apply, as do the penalties for transfer of assets.

Miller Trusts

If a person does not qualify for a spend down then they cannot qualify for Medicaid unless they use a “Miller Trust” into which all of that person’s income, or the amount of the income exceeding the Special Income Level, is placed into the trust. A “Miller Trust” is commonly referred to as a “Qualified Income Trust.” Essentially, once the trust is complete, the amount by which the gross income exceeds the Special Income Level is set as the spend down amount. The trust can be used to pay the spend down amount or any other deduction allowed by Medicaid. Under this trust, any income retained in the trust is paid to the State at the death of the recipient to help pay back the Medicaid assistance received. The reality is that there usually will be little or no funds left in the trust at the recipient’s death.

Miller Trusts are authorized under section 1917(d)(4)(D) of OBRA§1993 which provides Section 1917(d) (which states what trusts will disqualify a person for benefits) does not apply to “A trust established in a state for the benefit of an individual if...(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income into the trust).” Appendix G is a Miller Trust that has been accepted in an Indiana application for Medicaid waiver services.

The Miller Trust must be used when the person applying for waiver status has income above \$1,869 per month. The trust must be irrevocable. The excess income must be placed into the trust. The money in the trust can then be used to pay the minimum maintenance allowance to the spouse. I recommend obtaining a tax identification number for the trust. The trust will need to file an income tax return if it retains more than \$100

in income each year. Most Miller Trusts will pay out the income to the Medicaid recipient, spouse, or dependents, avoiding the need for a trust income tax return.

Aged and Disabled Medicaid Waiver

Home and Community-Based Services

1. Adult Foster Care. This is a new program in Indiana that has been successfully used in other states for many years. Three unrelated individuals over age 65 or who are at least 18 years old and disabled can live in an Adult Foster Care home. The individual must require nursing home level of care. The care provided may include transportation, medication assistance, companionship, and personal care. Meals are included. Providers are paid an additional amount by the state based on one of three levels, depending upon the care the individual needs. The person pays the Adult Foster Home the lesser of the SSI maximum, (which effective January 2007 is \$623 per month) for room and board or the person's income, less \$52 for the personal needs allowance.

The current list of Adult Foster Care providers can be found on the FSSA website.

2. Assisted Living. This is a wonderful program for folks that are independent enough to live in their own apartment type setting, but cannot afford private pay assisted living, and also meet the nursing home level of care requirement. Assisted living may be part of a retirement community, nursing home, or may be a stand-alone facility. The person pays the Assisted Living Facility the lesser of the SSI maximum, (which effective January 2007 is \$623 per month) for room and board or the person's income, less \$52 for the personal needs allowance. The current list of assisted living facilities enrolled in the Assisted Living Waiver Program is shown in Appendix H.

The Assisted Living Facility must:

- Be a Residential Care Facility licensed by the Indiana State Department of Health and be certified to provide Medicaid waiver services.
- Have 24-hour on-site staff.
- Provide a single unit that includes a kitchenette, living area, bathroom area, and toilet facilities.

The assisted living facility is paid by the State based upon a per diem amount for service levels 1-3. The services your client needs is determined by their score on the Level of Services Assessment Evaluation Tool (Appendix I). This score is re-computed each year and may be done more often if appropriate. Please note that the client's payment for room and board is paid in full each month no matter how many days the client is at the facility, and the state pays the facility only for the actual days the client is at the facility.

3. Adult Day Services. These are non-residential facilities that allow daily services for needy individuals for up to 10 hours per day. The provider is reimbursed by the State based upon one of three levels of care the individual needs. A list of approved providers can be found on the FSSA website. Transportation to and from the facility can be included as part of the Plan of Care.

4. Attendant Care. Provides assistance to meet the activities of daily living and ensures adequate support in a community-based setting.

5. Community Transition Support. This is a one-time-only benefit of up to \$1,000 to pay for set-ups and expenses to go from an institution to a home in the community.

Expenses such as security deposits, furnishings, utility deposits, and moving expenses are eligible for payment.

6. Case Management. All waiver clients must have a case manager. However, case management cannot be the only service in the Plan of Care.

7. Congregate Care. This service provides 24-hour room supervision and the coordination of other services by a subsidized housing provider for residence in an apartment/living unit owned and operated according to a Plan of Care for the individual.

8. Environmental Modifications. There is a lifetime cap of \$15,000 to pay for modifications to the home to ensure the safety of the client and to allow the client to function with independence in the home.

9. Environmental Modification Maintenance. There is a maximum of \$500 per year to repair or replace environmental modifications.

10. Home-Delivered Meals. A person who cannot prepare their own meals may have up to two meals per day delivered to his or her home.

11. Homemaker. General household activities that allow the person to stay at home in a clean and safe environment when the person is not able to otherwise manage the home.

12. Nutritional Supplements. These are dietary supplements such as Boost or Ensure that maintain a person's health in order to remain in the community.

13. Personal Emergency Response Systems Support. This is an electronic device that allows the person to obtain help in an emergency.

14. Pest Control. An allocation of up to \$600 per year to control pest infestations such as roaches, mosquitoes, fleas, etc.

15. Respite Care. Periodic, short-term care when a caregiver will not be there or needs a rest. Respite cannot be used for time when the caregiver is working or going to school. The levels of this service are: Homemaker, Attendant, Home Health Aide, and Nursing.

16. Specialized Medical Equipment and Supplies. Any service provided by waiver funds will not be a duplicate of what may be obtained through private insurance or traditional Medicaid. This service may allow for the purchase of computer adaptations, communications equipment, wheelchairs, safety devices, and vehicle modifications to allow community-based home services. Prior authorization is required for this service. There is a \$15,000 lifetime maximum amount for vehicle modifications. There is also an annual allowable maintenance fee of \$500 for vehicle maintenance for modifications that were paid for with waiver funds.

17. Transportation. Transportation to access waiver services and other community resources. This does not provide transportation to medical and therapy appointments.

The Snapshot Date

The Aged and Disabled Waiver program uses the Spousal Impoverishment rules to determine if a spouse qualifies for services (see Section 3300 of the ICES Manual). These rules will not apply if both spouses apply for waiver services. These rules follow the nursing home Spousal Impoverishment rules if the spouse applying for benefits has been in an institution for more than 30 days after September 30, 1989, with the first date of institutionalization being the “snapshot date.” If not, the snapshot date is the date the

Medicaid application is filed, unless the Medicaid application is filed before any of these dates, in which case the snapshot date is then the earliest of these dates:

1. The date the waiver slot is obligated for the individual. The Area on Aging Agency case manager performs the assessment and the client is deemed to meet the physical eligibility requirement, then the State approves the waiver. This takes about two (2) months;
2. The date on which level of care is approved;
3. The date on which the cost comparison budget is approved. Attached, as Appendix J, is a blank cost comparison budget form. This is the date the recipient gets the waiver slot, so it will almost always be the latest of the three dates.

In almost all Medicaid applications, the level of care approval will be completed first. Most level of care assessments are done by the case manager and supervisor at the AAA. If the client has a developmental disability or has mental retardation then a nurse waiver specialist in Indianapolis will make the final determination that an applicant meets nursing home level of care. The date level of care is approved or the date the Medicaid application is filed will almost always be the snapshot date if an applicant has not been in an institution for more than 30 days after September 30, 1989.

Indiana's Priority System for Obtaining Waivered Services

There are several priority categories for people who desire waiver services. One category includes people who are currently in the hospital or nursing home and have been there for at least 30 days. Another category of people are those who are at imminent risk

of nursing home replacement as a result of being discharged from a hospital or acute care facility. Persons who are currently receiving CHOICE services are also considered a priority. If a person has been targeted off of the waiver waiting list, they are also considered a priority. People who do not meet one of the priority categories may complete an application and be placed on the waiver waiting list.

The best way to apply for waiver services is to call in a referral to the information and assistance department in your local AAA for a Medicaid waiver program. Simply tell the operator that you want to make a waiver referral. Typically, the individual with whom you are making the referral will check the referred applicant's name, to see if he or she is already in the system, obtain demographic information, inquire about a brief medical history, and ask for contact information.

In Indiana, there are approximately 6,500 individuals on waiver services at present. CMS has approved 9,500 waiver slots. Currently, 600 applications for waiver services are being processed. In essence, services are available for individuals if there are participating providers available to process and support those needs.

The waiver programs are wonderful programs designed to help our clients age in place. As with many programs, it will take some time for the various organizations to understand exactly how the system is suppose to work. You will need to monitor the waiver applications for your clients to make certain they are properly processed. We have enclosed in Appendix K, a history of several waiver applications we are working on.

Sources of Information

Indiana Medicaid Home and Community Based Service Waiver Programs
(March 2007)
www.in.gov/fssa

Home and Community Based Service Waiver Provider Manual
(February 13, 2007)
www.indianamedicaid.com or order a copy from bddshelp@fssa.in.gov

Indiana State Plan for Aging and In-Home Services Fiscal Years 2007-2010
www.in.gov/fssa

The State of Indiana Renewal Request for Aged and Disabled Home and Community
Based Services Waiver Version D6-95

Money Follows the Person Rebalancing Demonstration
www.in.gov/fssa