Waiver 101

Presented By: *The Division of Aging*

What is a Waiver?

- *Section 1915(c) of the Social Security Act* permits states to offer, under a waiver of statutory requirements, an array of Home and Community-Based Services (HCBS) that an individual needs to avoid institutionalization.
- The term waiver refers to ***waiving of certain federal requirements that otherwise apply to Medicaid program services.***
  - For example, home and community-based services or "waivers" are *not* Medicaid entitlement programs.

Limitations

- Except in limited circumstances, a state may not claim Federal Financial Participation (FFP) for the costs of the room & board expenses of waiver participants.
  - Room & board expenses must be met from participant resources or through other sources.
- In its application, a state must specify the unduplicated number of individuals that the state intends to serve each year the waiver is in effect.
  - It is up to the state to determine this number, based on the resources that the state has available to underwrite the costs of waiver services.

Cost Neutrality

- In its application and each year during the period that the waiver is in operation, the state must demonstrate that the waiver is *cost neutral.*
- In particular, the average per participant expenditures for the waiver and non-waiver Medicaid services must be *no more costly* than the average per person costs of furnishing institutional (and other Medicaid state plan) services to persons who require the same level of care.

Assuring Participant Health and Welfare

- Specifying the qualifications of waiver providers and verifying that providers continuously meet these qualifications;
- Periodically monitoring the implementation of the service plan and participant health and welfare;
- Identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants; and,
- Instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights.

Participant Choice

- Must have choice of receiving services in an **institution** rather than in home and community based settings.
- Must have choice of **services**.
- Must have choice of **providers**.

Division of Aging Waiver Programs

- Aged and Disabled Waiver
- Traumatic Brain Injury Waiver

Provider Responsibilities Specific to the Waiver Program

- Providers must understand the service definitions and parameters for each service authorized on the Notice Of Action (NOA).
- All waiver providers are subject to audit and potential recoupment if the services provided are not in agreement with the services authorized as indicated on the approved NOA.
- If the needs of a waiver participant change, the provider must contact the case manager to discuss revising the service plan.

Provider Responsibilities, con't

- If a service can be funded under the state plan or Medicaid waiver, it is the provider's responsibility to seek state plan prior authorization before the service is requested as a Medicaid waiver service.
- Documentation of an appropriate prior authorization (PA) denial is required before the service is approved under waiver.
- An appropriate PA denial must be related to the actual service and not related to the PA process.
  - For example, a PA denial with the reason, provider did not submit required documentation, would not be considered an appropriate PA denial.

Provider Responsibilities, con't

- Pursuant to 455 IAC 2-8-4, providers are required to furnish at least thirty (30) days written notice before terminating waiver services to an individual. This notice must be made
    - to the individual,
    - the legal representative if applicable,
    - the individual's case manager and
    - the Division of Aging.

What is Level of Care

- The minimum needs that an individual must have to be considered eligible for the waiver.
- The A&D waiver requires Nursing Facility Level of Care
- The TBI waiver requires Nursing Facility Level of Care OR ICF/ID (formerly ICF/MR) level of care

Nursing Facility Level of Care

- Represents the compilation of medical, professional nursing and non-professional nursing-related needs of an individual based on an assessment of the individual's medical needs, physical, mental and cognitive abilities to ensure the health, safety and well being of the individual.

Who Makes the Level of Care Decision

- AAA: initial level of care determinations.
- Case manager: completes assessment and recommends approval or denial
- AAA supervisor: can review and issue a decision
- Non-AAA case managers: can be recommendations on non-initial level of care decisions but DA reviews and issues decision
- Division of Aging: final authority, reviews level of care as part of the review process with every service plan submitted

Notification of Level of Care Decisions

- Level of Care Review Form
  - Issued with every determination – approvals and denials
  - Must be provided to the client within 10 business days by mail or e-mail
  - Appeal rights must be provided as well
- Issued by AAA or by DA when the case manager is with a non-AAA agency

Aged and Disabled Waiver Program

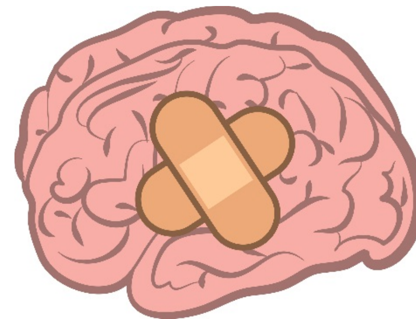
- Last five year renewal approved by CMS was effective July 1, 2013.
- The A&D waiver year runs from July through June.
- For the current waiver year, Indiana is approved to serve 16,081 individuals through the A&D waiver
- So, far, since July 1, 2014, we have served just under 14,000 individuals.

Aged and Disabled Waiver Program

- Eligibility requirements:
  - Eligible for an appropriate aid category of Indiana Medicaid
  - Nursing facility level of care (*405 IAC 1-3.)*

Traumatic Brain Injury Waiver

- Last five year renewal approved by CMS was effective January 1, 2013.
- The TBI waiver year corresponds to the calendar year, running January through December.
- Indiana is approved to serve 200 individuals each waiver year through the TBI waiver.



Traumatic Brain Injury Waiver

- Eligibility requirements:
  - Eligible for an appropriate aid category of Indiana Medicaid
  - Institutional level of care, either
    - Nursing facility level of care (*405 IAC 1-3.)*, or
    - ICF/IID (formerly ICF/MR) level of care.
  - Diagnosis of ***traumatic*** brain injury (note must be traumatic, not anoxic)

Definition of 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.

Definition of Traumatic Brain Injury

- 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.

Waiver Services

- Adult day services (A&D and TBI)
- Adult family care (A&D and TBI)
- Assisted living (A&D and TBI)
- Attendant care (A&D and TBI)
- Behavior management/behavior program and counseling (TBI only)
- Case management (A&D and TBI)
- Community transition (A&D and TBI)
- Environmental modification (A&D and TBI)
- Environmental modification assessment (A&D only)
- Healthcare coordination (A&D and TBI)
- Home-delivered meals (A&D and TBI)

Waiver Services continued

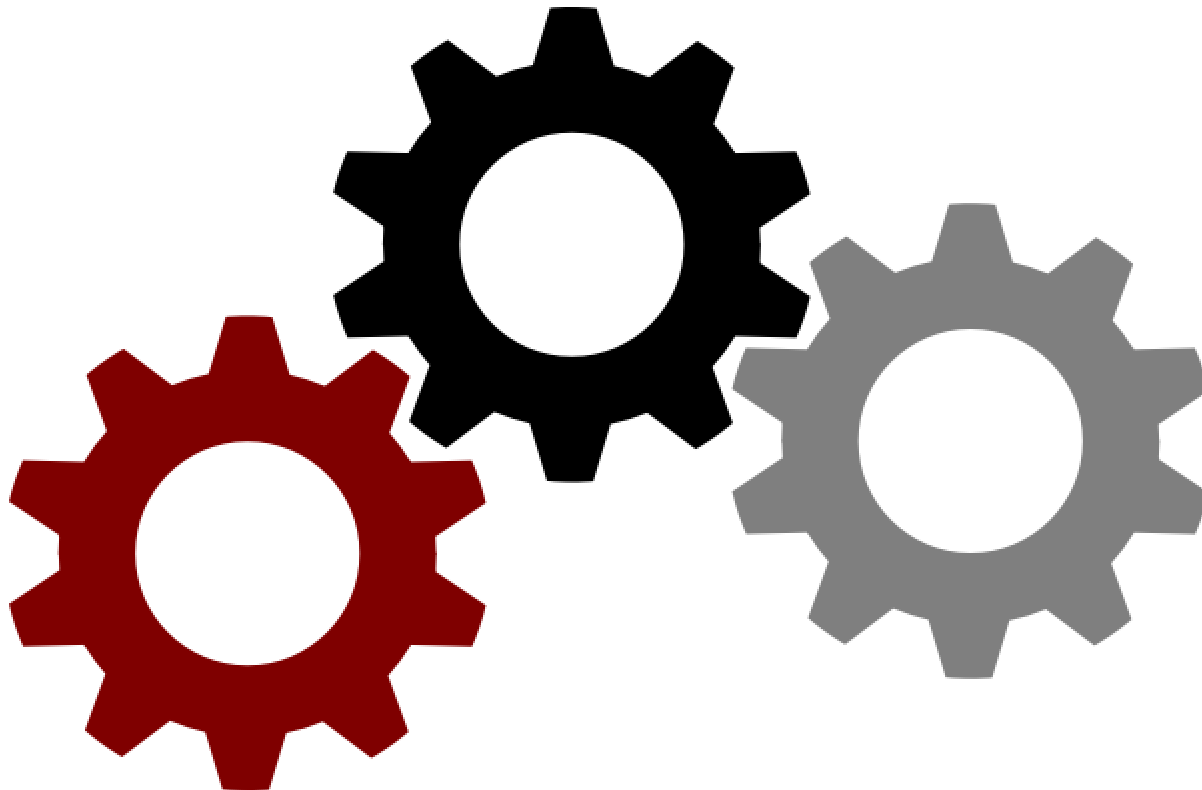
- Homemaker (A&D and TBI)
- Nutritional supplements (A&D and TBI)
- Personal emergency response system (A&D and TBI)
- Pest control (A&D and TBI)
- Residential-based habilitation (TBI only)
- Respite care (A&D and TBI)
- Structured-day program (TBI only)
- Structured family caregiving (A&D only)
- Specialized medical equipment and supplies (A&D and TBI)
- Supported employment (TBI only)
- Transportation (A&D and TBI)
- Vehicle modification (A&D and TBI)

Resources

- Waiver Basics – CMS Training for Case Managers, http://www.hcbsassurances.org/basics/basics1.html
- CMS 1915 (c) Waiver Application Instructions
- TBI Waiver Renewal
- A&D Waiver Renewal
- Division of Aging Medicaid Waiver Provider Manual

http://www.in.gov/fssa/da/3476.htm

Let's switch gears….



Person Centered Thinking and Practice for Division of Aging

Developed By the Division of Aging with Support From:

Service Plans

Diagnosis *creates* impairment, impairments *create* need, and needs *shape* the service plan

- Person-Centered Planning includes *all* supports

✓ Waiver Services
✓ Informal Supports
✓ Community Resources

✓ Other public funds
- Medicaid prior approval services
- Medicare
- VA
- Hospice

Service Plan Development

- The Plan should address all identified needs.
- Services should be appropriately used based on the waiver guidelines and the level of need identified in the assessment process.
- Amounts of services being authorized should make sense in relation to the needs that have been identified.

Person Centered Planning

- The development of the service plan must be guided by the participant
- Necessary information and support should be provided to ensure the person and/or representative is central to the process, and understands the information.
- Provide supported decision making

Person Centered Planning

- Supply information need to make informed choices
  - What services are available
  - What are the limitations of each service
  - A list of providers that they can select from
- Must assure the health & safety of the person.

Provider Selection

- Participants must have a choice of providers
- Provide a pick list from INsite based on the county and the service needed
  - Pick list must be generated as need (don't just make copies)
- Not just choice, but informed choice
  - For example, if client will require the homemaker provider to run errands for them, some providers do not provide that task; pointing out which agencies do helps them have informed choice

Service Plan Authorization

- The participant or their representative and case manager sign the service plan.
- The DA reviews the service plan - this may result in a request for additional information, an approval or a denial.
- The DA's review is intended to assure that the participant's goals, needs (including healthcare needs), and preferences are met.
- Upon decision (approval or denial) a Notice of Action is issued. That notice is the official authorization for the provider to provide services as approved.

Monitoring of the Service Plan

- The service plan implementation and effectiveness is review as part of each required 90 day review
- Updates to the service plan can be made as often as necessary to reflect the participant's medical needs, goals, and preferences.
- Service plan must updated/renewed at least every 365 days (annual plan).

Division of Aging Core Values

We support people in having -

- Choice
  - The person decides
- Direction
  - The person determines what, where, how much
- Control
  - The person determine how this process works

Person Centered Thinking

- Underlies and guides respectful listening which leads to actions, resulting in plans that support people in:
  - Having positive control over the life they desire;
  - Being recognized and valued for their contributions (past, current, and potential) to their communities; and
  - Being supported in a web of relationships, both natural and paid, within their communities

IMPORTANT *TO*,
IMPORTANT *FOR*
&
THE BALANCE BETWEEN THEM

Important *TO…*

What is important to a person includes those things in life which help all of us to be satisfied, content, comforted, fulfilled, and happy. It includes:

- ☺Relationships
- ☺Status and control
- ☺Things to do/Places to go
- ☺Rituals or routines
- ☺Rhythm or pace of life
- ☺Things to have

Important *FOR*...

- Issues of health:
  - Prevention of illness/injury
  - Treatment of illness/injury/ medical conditions
  - Promotion of wellness (e.g.: diet, exercise)
- Issues of safety:
  - Environment
  - Well being ---- physical and emotional
  - Free from fear, exploitation

Important *FOR*…

- What others see as necessary to help the person:
  - Be valued
  - Be a contributing member of their community

The Balance

Person-Centered Training

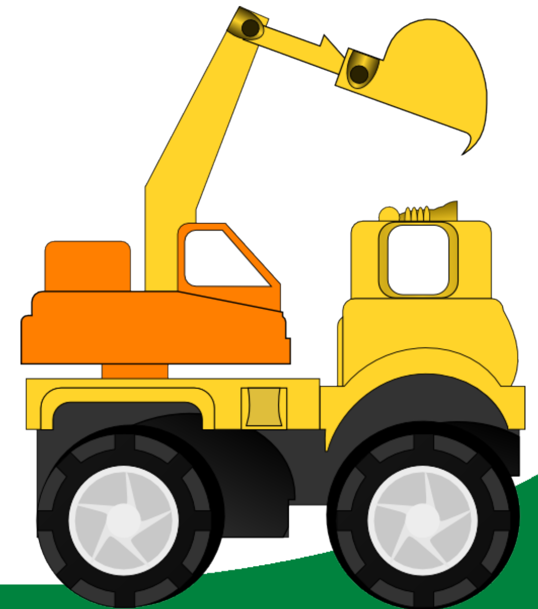
- Core Trainers:
  - Karen Wolfe, Care Management Team Leader
  - Erin Davis, Area 16
  - Kimberly Self, Area 11
  - Amanda Mowery, Area 6
  - Chelsea Perry, Area 8
- Training Dates
  - Goal is January & March
  - Two-Day Training

Eventually, all Care Managers will be trained

The Learning Community for person centered practices

Under Construction

- Stay tuned as we grow in our Person-Centered practice!
- Currently working to form a community of practice in Indiana
  - Ongoing training
  - Support of Care Managers
  - Training in Tools & Best Practice



The Learning Community
for person centered practices

The Learning Community for Person Centered Practices envisions a world where all people have positive control over the lives they have chosen for themselves. Our efforts focus on people who have lost or may lose positive control because of society's response to the presence of a disability. We foster a global learning community that shares knowledge for that purpose.

www.learningcommunity.us

Thank you!

For further questions please contact:

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