



Indiana Family and Social Services Administration

Health and Provider Services
January 6, 2010





MEDICAID OVERVIEW

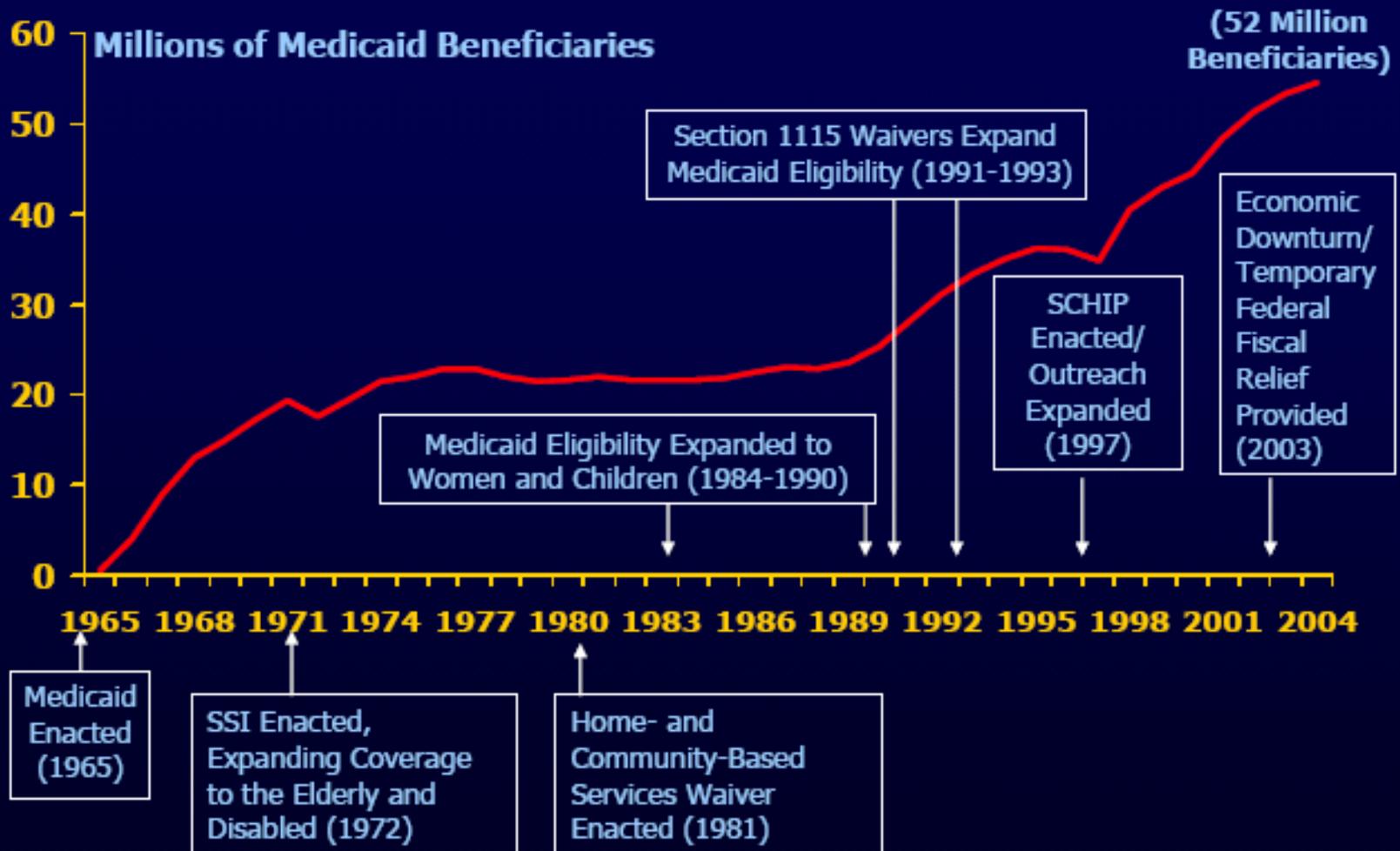


Medicaid's Origin

- Enacted in 1965 as companion legislation to Medicare
- Established as an entitlement
 - Provides federal matching grants to states to finance health care
 - Focus on the low-income and disabled population
 - Single parents with dependent children
 - Aged, blind, and disabled
- Includes mandatory services and allows state options for broader coverage
 - States have different eligibility levels and benefits packages
 - Optional services Indiana covers include¹: chiropractic care, dental services for adults, Medicaid rehabilitation option, prosthetic devices, eyeglasses, durable medical equipment, prescription drugs

1. This is not a comprehensive list of optional services covered by Indiana Medicaid.

Medicaid's Evolution



SOURCE: KCMU analysis of data from the Health Care Financing Administration and Centers for Medicare and Medicaid Services, 2004.



Medicaid & Federal Funding

- Medicaid is a state administered program.
- States provide funding for their Medicaid program that is matched by federal dollars.
 - For every dollar the State spends, the federal government matches with approximately two dollars.
 - The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of federal matching funds for state expenditures.¹
 - Indiana's FFY2008 FMAP = 65.93%
 - Indiana's FFY2010 enhanced FMAP (ARRA) = 75.69%

1. (www.aspe.hss.gov/health/fmap.htm)



Medicaid & ARRA

- Beginning October 1, 2008, each state is eligible for a minimum of 6.2% point increase to its current FMAP.
- Centers for Medicare and Medicaid Services (CMS) calculates state unemployment add-on rates each quarter.
- Base FMAP cannot be reduced.
- ARRA funding is only available for states compliant with maintenance of effort (MOE) restrictions.
 - Restricts changes in eligibility determination or redetermination process, or procedures that are more stringent or restrictive than those in effect under the state Medicaid program on July 1, 2008.
 - Prompt Pay Provision applicable to practitioner, hospital, and nursing facility provider claims.
- Beginning March 30, 2009, general fund appropriations were withheld from the Medicaid program and replaced with ARRA funding.



Office of Medicaid Policy and Planning (OMPP)

- OMPP is one of five FSSA divisions and is responsible for:
 - Administering Medicaid programs
 - Performing medical review of Medicaid for the Aged, Blind, and Disabled (MRT)
- OMPP relationships with other divisions & agencies
 - CMS: Federal partner who must approve state Medicaid programs
 - Division of Family Resources: Financial eligibility for Medicaid
 - Division of Aging: Traumatic Brain Injury & Aged and Disabled waivers
 - Division of Disabilities and Rehabilitative Services: Support Services, Developmental Disability, and Autism waivers
 - Division of Mental Health and Addiction: Medicaid Rehabilitation Option (MRO) services, CA-PRTF grant
 - DCS: All wards of the State are eligible for Medicaid benefits
 - DOC: Coordination of services for Medicaid eligible individuals exiting correctional facilities



Medicaid Enrollment since 2002

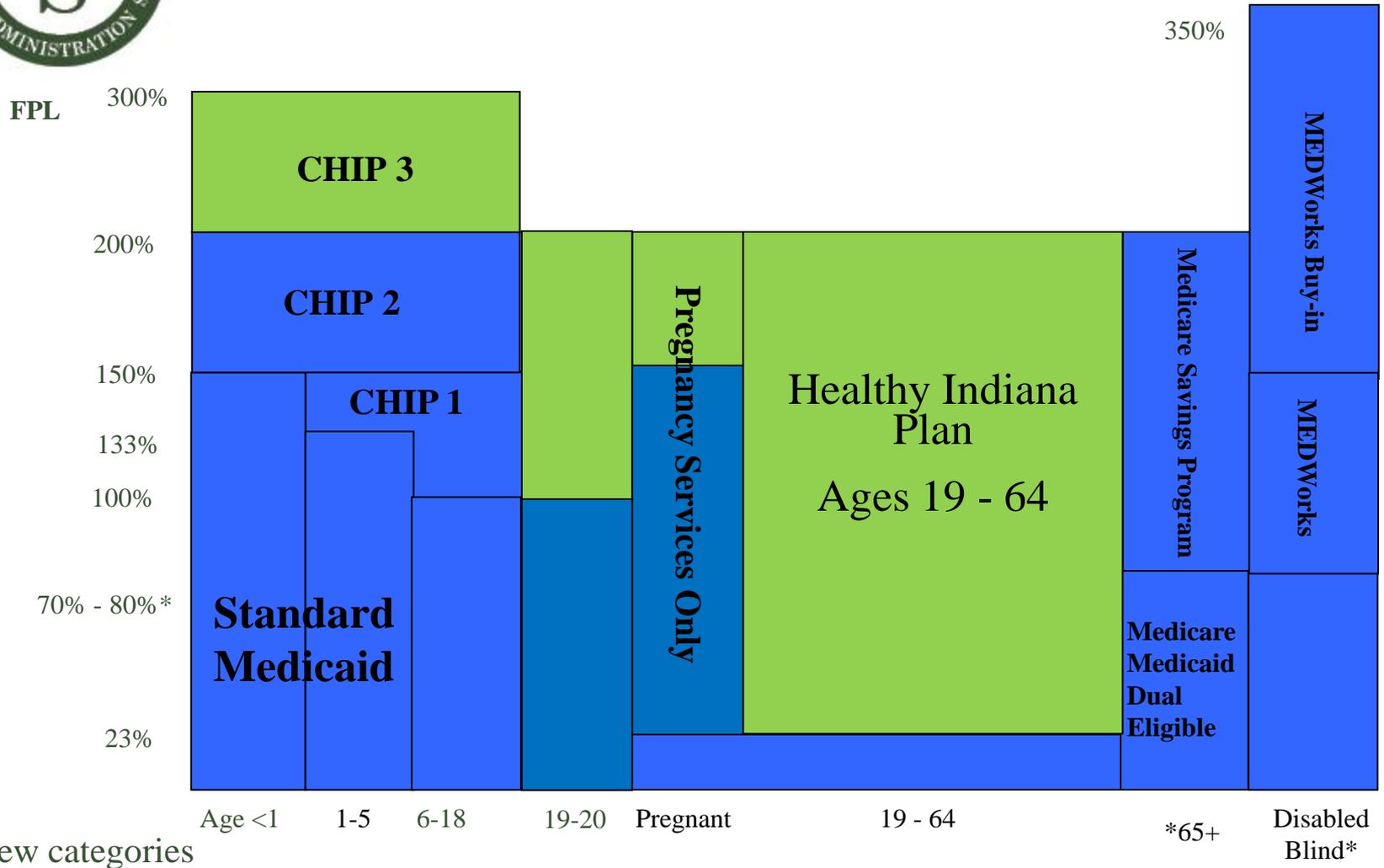
Recipients (as of June 30 annually)								
	2002	2003	2004	2005	2006	2007	2008	2009
Medicaid	756,904	777,170	822,344	847,625	857,599	877,933	920,332*	1,017,571*

* Medicaid increases in 2008 & 2009 resultant of HIP program (18,903 members in 2008 & 50,115 members in 2009)

Source: ICES



Medicaid Eligibility: New & Existing Categories

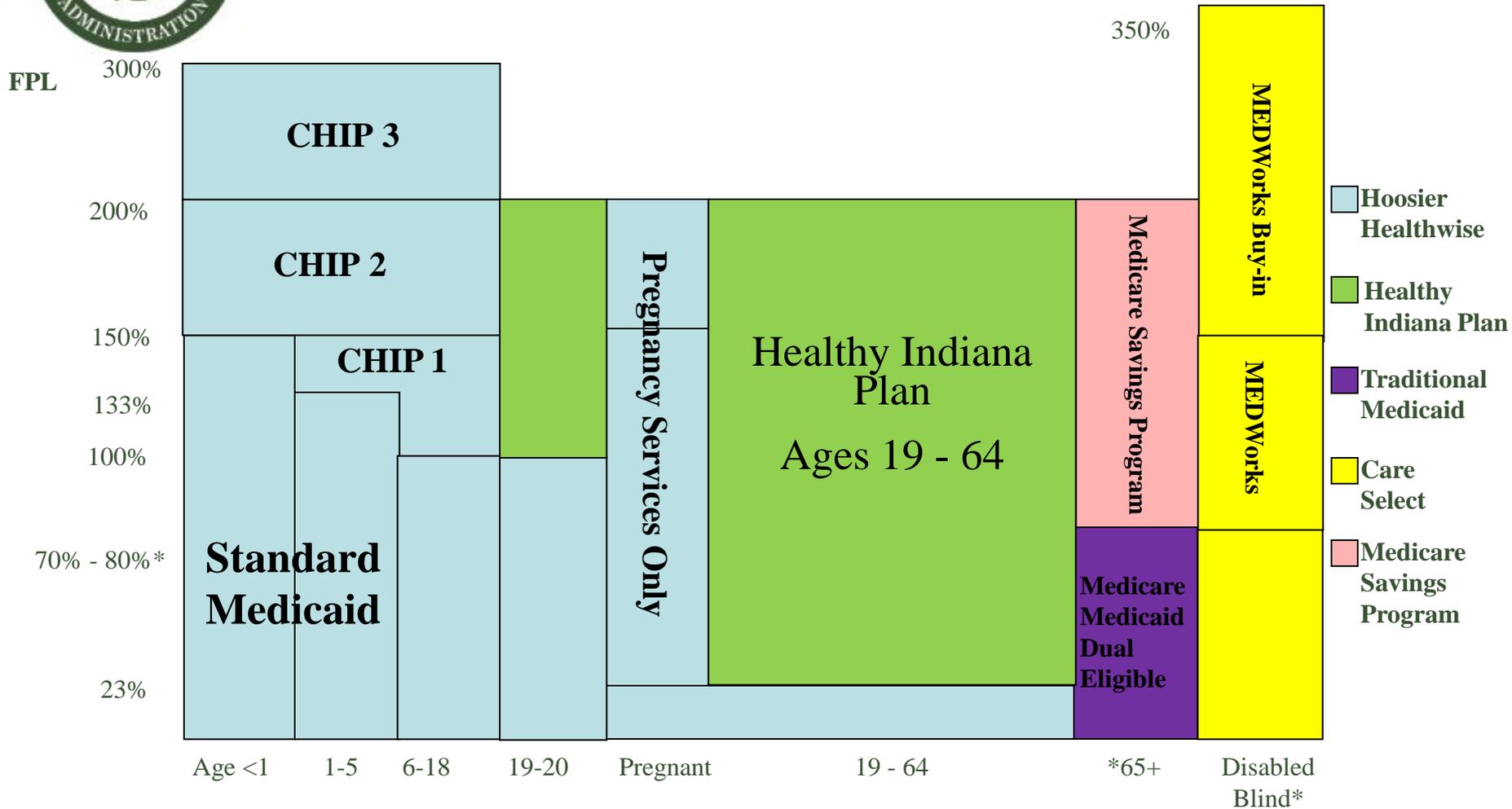


■ New categories
■ Existing Medicaid categories

*Aged, Disabled and Blind income eligibility is driven by SSI standards rather than FPL



Medicaid Eligibility by Program



* Aged, Disabled, and Blind income eligibility is driven by SSI standards rather than FPL



Medical Review for Medicaid Disability

- For an individual to qualify for the physically or mentally disabled category of Medicaid, a review of the individual's medical records and sometimes additional medical tests are needed to make a medical eligibility decision.
- Under the Social Security Act, states have the option of conducting medical review for Medicaid disability in one of two ways:
 - Section 1634: states may contract with the Social Security Administration to determine eligibility for Medicaid at the same time a determination is made for receipt of SSI benefits.
 - Section 209(b): states may choose to operate under a more restrictive Medicaid eligibility criteria for their aged, blind and disabled recipients than are used in the SSI program in one or more eligibility areas.
- Since 1972, Indiana has operated as a 209(b) State. As such the OMPP's MRT unit conducts medical reviews for disability.



Spend-down

- Spend-down allows individuals who are medically eligible for Medicaid, but do not meet financial eligibility requirements, to receive Medicaid benefits.
- Individuals with a spend-down have a monthly “deductible” of medical bills that must be paid by the individual before Medicaid will pay for medical services.
- Providers and the individual may submit medical receipts to be counted toward the individual’s spend-down.



Presumptive Eligibility for Pregnant Women

- Presumptive Eligibility (PE) is a federally recognized Medicaid State Plan option.
- PE allows a pregnant woman to receive ambulatory prenatal services while her Hoosier Healthwise application is being processed, this program began on July 1, 2009.
- The woman may remain on PE until her Medicaid application is approved or denied, or her pregnancy ends.
- Providers that bill for services while a woman is on PE will still receive reimbursement if the woman is later found ineligible for Medicaid.
- As of December 30, 2009, 5,232 women have received Medicaid services under PE.



Managed Care: Hoosier Healthwise

- Hoosier Healthwise (HHW), an entitlement program, operates under an 1115 waiver authorized by CMS.
- HHW includes coverage for Indiana children (including the Children's Health Insurance Program (CHIP)), pregnant women, and low-income families.
 - CHIP is federal program that provides states the option to fund health coverage for uninsured children who are above income eligibility guidelines for Medicaid. CHIP is funded through a separate pool of federal funds.
- The goals of HHW are to:
 - Ensure access to primary and preventive care services
 - Improve access to all necessary health care services
 - Encourage quality, continuity, and appropriateness of medical care
 - Provide medical coverage in a cost-effective manner
- There are 3 packages (A, B & C) with different financial eligibility requirements.
- Hoosier Healthwise is administered by the following Managed Care Organizations (MCOs):
 - Anthem
 - Managed Health Solutions (MHS)
 - MDwise



Managed Care: Care Select

- Care Select (CS), an entitlement program, operates under a 1915(b) waiver authorized by CMS.
- Individuals receiving Medicaid under the following categories are covered by CS:
 - Aged, blind, and physically or mentally disabled
 - Members receiving adoption assistance
 - Members in the Waiver Program
 - M.E.D. Works participants
 - Wards and foster children
- CS is a care management program created by FSSA to:
 - Tailor benefits to people more effectively
 - Improve the quality of care and health outcomes
 - Provide a more holistic approach to members health needs
- Care Select is administered by the following Care Management Organizations (CMOs):
 - Advantage Health Solutions
 - MDwise



Managed Care: Healthy Indiana Plan

- Healthy Indiana Plan (HIP) is a Medicaid program operated under an 1115 waiver authorized by CMS and is **not** an entitlement program.
- Covers adults ages 19-64 who meet four eligibility criteria:
 - Below 200% FPL
 - No access to employer-sponsored insurance
 - Have not had health insurance within the last 6 months
 - Are not eligible for another Medicaid category
- Consumer-driven, voluntary health insurance program that promotes personal responsibility and value-conscious decisions.
- All participants have Personal Wellness and Responsibility Accounts (POWER Accounts).
 - Members make a monthly financial contribution towards their health care on a sliding scale (2% to 5% of \$1,100 based on income).
- HIP is administered by the following Managed Care Organizations (MCOs):
 - Anthem
 - MDwise
 - Enhance Services Plan (ESP)



Medicare Savings Program

- The Medicare Savings Program (MSP) provides benefits to eligible Medicare beneficiaries to pay for Medicare premiums
 - **Qualified Medicare Beneficiary (QMB)** the state pays the Medicare Part A and Part B premiums and out-of-pocket expenses for Medicare services
 - **Specified Low-Income Medicare Beneficiary (SLMB)** the state pays the Medicare Part B premium
 - **Qualified Individual (QI)** the state pays the Medicare Part B premium
- When an individual enrolls in an MSP, he/she automatically receives full “Extra Help” for Part D drug coverage
 - Extra Help is a federal program that helps pay for most of the costs of the Medicare drug benefit (Part D), including the gap in coverage



2009 Accomplishments & 2010 Initiatives

2009

- CHIP expanded to 250% FPL
- Notice of Pregnancy and Presumptive Eligibility for Pregnant Women

2010

- Expanded mental health benefits for the CHIP population
- Pharmacy Benefit Consolidation
- Expand CHIP to 300% FPL
- Add HIP non-caretaker slots (pending CMS approval)
- Suspension of Eligibility for Delinquent Children



HOME AND COMMUNITY-BASED WAIVERS



Waivers for Individuals with a Developmental Disability

- Developmental Disabilities (DD) waiver assists children and adults with a developmental disability to:
 - Become involved in the community where one lives and works
 - Develop social relationships at home and at work
 - Develop skills to make decisions about how and where to live
 - Be as independent as possible
- Autism (AU) waiver is the same as the DD waiver with the following exceptions:
 - Individual must be diagnosed with Autism
 - Services new for the DD waiver in 2009 are not yet available for the AU waiver (pending renewal of AU)
- Support Services (SSW) waiver is the same as the DD waiver with the following exceptions:
 - Annual cap of \$13,500
 - Services new for the DD waiver in 2009 are not yet available on the SSW waiver (pending renewal of SSW)



Waivers for Individuals Whose Needs are Primarily Medical in Nature

- Aged & Disabled (A&D) waiver supplements informal supports for individuals who would otherwise require care in a nursing facility. Indiana's 16 Area Agencies on Aging (AAA's) act as entry points for this waiver. Assists the individual to:
 - Be as independent as possible; helps individuals remain at home as well as assists people living in nursing facilities to return home or to a community setting
 - Live in the most independent setting possible while maintaining health and safety
- Traumatic Brain Injury (TBI) waiver supports individuals of any age who have experienced an external insult resulting in a TBI, and who require services typically only available in a nursing facility. Assists the individual with:
 - Personal assistance
 - Limited habilitation services
 - Respite care
 - Limited environmental modifications



DISPROPORTIONATE SHARE HOSPITAL PAYMENTS



Disproportional Share Hospitals (DSH)

- Disproportional Share Hospital (DSH) adjustment payments provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients.
 - Eligible hospitals are referred to as DSH hospitals.
- States received an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, CHIP or other health insurance.
- This annual allotment is calculated by law and includes requirements to ensure that the DSH payments to individual DSH hospitals are not higher than these actual uncompensated costs.



INTERGOVERNMENTAL TRANSFERS



Intergovernmental Transfers

- Intergovernmental Transfers are defined by federal code at 42 CFR 433.51.
- Municipal hospitals provide IGTs for the state share of their own UPL and DSH payments.
- Indiana University and Health and Hospital Corporation of Marion County provide IGTs for the state share of UPL and DSH payments to private hospitals and Wishard, as worked out by their agreement.
- IGTs provided for other payments including MRO, Nursing Facility UPL, and Physician Faculty Access to Care Payments.



DIVISION OF AGING



Division of Aging - Responsibilities

- **Oversee Nursing Facility Level of Care Waivers**
- **Approve Level of Care**
 - Determinations & Care plans from Area Agency on Aging (AAA) case managers
- **Provider enrollment**
 - For Medicaid Waiver providers



Division of Aging - Responsibilities

- Surveys and Certifies participation in
 - Adult Day Service, Adult Foster Care, Assisted Living Facilities
- Administers other Home and Community Based Services (HCBS)
 - Community & Home Options to Institutional Care for the Elderly and Disabled (CHOICE)
 - Title III Support Services
 - Social Services Block Grant (SSBG)
 - Federal Nutrition Funds



Division of Aging - Responsibilities

- Oversees Nursing Facility rates, policies and expenditures
- Administers Residential Care Assistance Program (RCAP)
- Administers State Long Term Care Ombudsman and Adult Protective Services programs
- Administers Money Follows the Person (MFP) program
- Monitors incident reporting and Quality Assessment (QA) for waiver clients



Nursing Facility Reimbursement

- Case Mix System
 - Uses information from Minimum Data Set (MDS)
 - Flows into Resource Utilization Groups (RUGs) for each client
 - Facility wide Case Mix Index (CMI) established
 - Used to impact the Direct Care Component



Nursing Facility Reimbursement

- Quality Assessment
 - Fee paid by each nursing facility with exception of
 - Continuing Care Retirement Communities (CCRCs)
 - Hospital based facilities
 - Indiana Veteran's Home
 - 80% returns to nursing homes
 - 20% goes to State for Medicaid expenditures
 - Leveraged thru Federal Medicaid expenditures
 - Approximately \$100M annually in enhanced payments to nursing homes



Nursing Facility Reimbursement

- Restructure of nursing home reimbursement rules:
Phase II
 - To reduce nursing home utilization
 - To increase HCBS utilization
 - Reward quality care and services



Aged & Disabled Waiver

- Eligibility
 - Nursing facility level of care
 - Medicaid eligibility requirements
 - Aged (65 or older) or
 - Disabled



Aged & Disabled Waiver

- Services Available

- Adult Day Services
- Adult Foster Care
- Assisted Living
- Attendant Care
 - Includes self-directed
- Community Transition
- Environmental Modification
- Home Delivered Meals
- Nutritional Supplements

- Services Available

- Homemaker
- Personal Emergency Response System
- Pest Control
- Respite Care
- Specialized Medical Equipment
 - Includes vehicle modification
- Transportation



Aged & Disabled Waiver

- Targeted all clients on waiting lists August 2008
 - Added over 2000 individuals; no waiting lists
 - Reduced time to get client into service from >200 days to <55
 - Slots full (10,409); budget prohibits expansion:
December 3, 2009



Aged & Disabled Waiver

- Year 3 (7/1/10-6/30/11): 11,802
- Year 4 (7/1/11-6/30/12): 12,928
- Year 5 (7/1/12-6/30/13): 13,838



Community & Home Options to Institutional Care for the Elderly and Disabled (CHOICE)

- Eligibility
 - Any age with mental or physical disability at risk of losing independence
 - Adults 60+ primary focus
 - 20% of funds spent on <60
 - Assets must not exceed \$5,000



Community & Home Options to Institutional Care for the Elderly and Disabled (CHOICE)

- In-home and community services provided
 - Adaptive aids and devices
 - Attendant care
 - Environmental modifications
 - Home health services
 - Information and assistance
 - Nutrition education/counseling
 - Respite care
 - Transportation
 - Adult day services



Community & Home Options to Institutional Care for the Elderly and Disabled (CHOICE)

- In-home and community services provided
 - Case management
 - Family caregiver support
 - Home delivered meals
 - Home repair and maintenance
 - Legal assistance services
 - Outreach services
 - Therapy services
 - Self-directed attendant care services
 - Other services necessary to prevent institutionalization



Other Non-Medicaid Title III

- Title III Support Services
 - Meals
 - HCBS
 - Family Caregiver Support
- Social Services Block Grant (SSBG)
 - HCBS