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Retroactive payments for waiver services not permitted prior to approved Medicaid eligibility

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As announced on January 17, 2024, in the Medicaid Forecast Updates and Initiatives, FSSA is implementing system changes that will prevent retroactive coverage of Aged & Disabled (A&D) and Traumatic Brain Injury (TBI) waiver services before Medicaid eligibility has been approved. The system changes will go into effect March 27, 2024 and will bring FSSA into compliance with its current waiver authority. These changes will also apply to the Health and Wellness (H&W) and PathWays waivers effective July 1.

Reimbursement for waiver services in an individual's initial waiver service plan under the A&D or TBI waiver plans will not be allowed if the service is provided before the individual's Medicaid eligibility has been approved. Medicaid approval means an individual meets all eligibility requirements, including financial requirements, to qualify for full coverage Medicaid.[1] As has always been the case, an individual must also meet functional eligibility to qualify for the waiver's level of care (LOC) requirements. An Area Agency on Aging (AAA) may begin service plan conversations with individuals once functional eligibility is established and the individual is pursuing Medicaid eligibility. Providers should verify not only that an individual meets functional eligibility requirements for the waiver but that they have Medicaid eligibility for the waiver. Providers can verify coverage in the IHCP portal.

In summary, waiver services should not be provided prior to Medicaid eligibility being approved. Retroactive payments for waiver services will not be allowed. Individuals waiting for a Medicaid eligibility determination should continue to be assessed for changes to their functional eligibility at their local AAA to ensure the initial service plan is current and can be implemented upon approval of an individual's Medicaid eligibility.

[1] For more information about which Medicaid coverage allows for waiver services, please reference this Medicaid aid category document in the final column "HCBS Waiver Compatible?"

FAQs - Retroactive Eligibility under the A&D & TBI Waivers

Medicaid Eligibility

1. What do I have to do in order to be eligible for and receive services on the Aged & Disabled (A&D) waiver or Traumatic Brain Injury (TBI) waiver?
    a. There are two required eligibility steps. You must meet both functional and Medicaid eligibility requirements. These steps can happen concurrently or one after the other.
2. What is "functional eligibility"?
    a. Functional eligibility, sometimes referred to as a "level of care" decision, is an assessment and determination regarding the ability or inability of a person to complete certain activities of daily living (ADLs) such as eating, dressing, bathing, etc. You will be assessed by your Area Agency on Aging (AAA).
3. What is "Medicaid eligibility"?
    a. Medicaid eligibility is the process of determining if a person meets all criteria to receive Medicaid, such as Indiana residency, financial qualifications, etc. This process is conducted by the FSSA's Division of Family Resources (DFR) when you submit an application. In some cases, the AAA may assist you with submitting your Medicaid application.
    b. You must have both functional eligibility and Medicaid eligibility to receive A&D or TBI waiver services.
4. What is a "Medicaid approval date"?
    a. The Medicaid approval date is the date when a person's Medicaid eligibility application is complete and approved by the DFR. The approval date is the mailing date listed on the approval letter.
5. What is a "Medicaid effective date?"
    a. The Medicaid effective date is the date Medicaid services begin. The Medicaid effective date may be different than the Medicaid approval date. For most types of Medicaid, an individual can be covered for up to three months before the month they apply if they would have qualified for Medicaid in each of those months.
6. Can I receive any services prior to Medicaid approval, and what limits are there?
    a. For approved months between the effective date and the approval date, **you can receive a Medicaid State Plan service retroactively for up to 90 days**. When calculating this 90-day retroactive period, you should use the Medicaid approval date. For instance, primary care and hospital visits may be covered 90 days retroactively. If this applies to a person's Medicaid, a retroactive date will be listed on the approval letter.
    b. Under the approved Waiver language, **A&D and TBI waiver services are not covered retroactively**. Waiver services may be accessed starting on the "Medicaid approval date."
7. I have been receiving both Medicaid State Plan and A&D or TBI waiver services but recently learned I lost my Medicaid. Can I still receive A&D waiver services that are authorized in my current waiver service plan even if I don't have Medicaid eligibility?

    a. No. You must have Medicaid eligibility to also receive Medicaid Waiver services—and this applies to any A&D or TBI waiver services authorized as part of an approved waiver service plan.
8. If I get my Medicaid eligibility back, will I be able to automatically resume all A&D or TBI waiver services included in my approved waiver service plan at the time I lost Medicaid eligibility?
    a. If your Medicaid eligibility is reinstated through an administrative action such as agency reconsideration or through an appeal, A&D or TBI waiver services approved in your existing service plan will also be reinstated and will be aligned with your Medicaid eligibility. If Medicaid eligibility is retroactively applied in this instance for a period of time you should have been eligible, waiver services should be retroactively reinstated for the same period of time.
9. Where do I apply for Medicaid?
    a. If you are applying to Medicaid, you will need to submit an application in person, online, by mail, or by the phone. Once you submit your complete application, it can take up to 90 days to determine if you are eligible. Please note, if any information is missing or later requested, the timeframe for approval is paused until the State receives the accurate or updated information. More information on the application process can be found here. To help find out what Indiana State Benefits you may be able to get if you apply, please go here.
10. What can I do to ensure my Medicaid information is up to date to prevent delays?
    a. You should sign in or create an account to report your correct address and contact information in order to maintain your coverage in FSSA's Benefits Portal linked here. This will help to prevent a delay in receiving Medicaid re-approval and thus receiving timely waiver services. Additional Medicaid coverage Q&As are located here.
    b. If you are unable to access the portal online, you can call the DFR office at 800-403-0864 toll free.
11. Does this change impact the Family Supports Waiver (FSW) and Community Integration and Habilitation (CIH) waiver?
    a. This change does not impact these waivers. Policies preventing coverage of waiver services before Medicaid eligibility is already in place is for the A&D or TBI waivers.
12. How can I get help if I'm waiting for the Medicaid eligibility process to be completed?
    a. You should communicate with the DFR and your AAA to ensure they have all information needed to process your application as quickly as possible.
    b. Additional supports in your community may be available while you wait. AAAs and other community resources such as 211 can help you determine if other supports are available while you are working toward Medicaid and waiver coverage. If you receive Medicare benefits, you can reach out to the State Health Insurance Assistance Program (SHIP).

Services & Waiver Service Plans

13. What if my needs have changed since we established my initial service plan?
    a. Providers are responsible for adhering to the services approved in the Notice of Authorization (NOA) for services. If the service plan needs to be updated with additional hours to meet the needs of the waiver member, your care manager should update the service plan in advance of changing the number of hours provided. If there are circumstances that would prevent adding hours before starting additional service hours,

providers must notify the care manager within 90 days in order for hours to be added retroactively.

14. Does this guidance regarding retroactive coverage also apply to Medicaid programs such as Hoosier Healthwise, Healthy Indiana Plan (HIP), or Hoosier Care Connect (HCC)?
    a. No. This guidance is specific to Home and Community Based Services (HCBS) through the A&D or TBI waivers.
15. Does any of this change for individuals when PathWays for Aging is available in July 2024?

This same process will be in place for both PathWays for Aging and for the Health & Wellness (H&W) waivers. Any changes to the eligibility process due to the move to PathWays and H&W will be communicated separately prior to the transition.