

Medicaid Eligibility and Medicaid Services

Supplemental Resources

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This document contains the forms, tables, lists, and websites that were either displayed or referred to in the Overview of Waiver Support Coordination Pre-Service training. This document also contains additional resources to aide new WSCs in gaining the skills necessary to effectively coordinate the supports and services for individuals on their caseload.

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Medicaid Eligibility and Medicaid Services

APD and Waiver Eligibility Requirements

A person receiving iBudget waiver services must be both a client of APD and be eligible to receive Medicaid benefits. This means that individuals on your caseload must be:

- APD Eligible
- Eligible for waiver services, and be
- Eligible to receive Medicaid benefits.

Someone who is eligible to be served by APD may not be eligible for waiver specific services. Each of your clients must meet specific criteria at the time of their application process. The eligibility criteria for APD services is defined in Chapter 393, Florida statutes. These criteria include:

- Intellectual Disability (Full Scale IQ $70 \leq$ for APD services; $59 \leq$ for Waiver services),
- Severe forms of Autism,
- Spina Bifida cystica or myelomeningocele,
- Cerebral Palsy,
- Prader-Willi syndrome,
- Down syndrome,
- Phelan-McDermid syndrome, or
- Individuals between the ages of 3-5 at high risk for a developmental disability.

In order to be eligible for waiver services, an individual must have one of the disabilities mentioned previously and meet the level of need to be served in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID).

Verifying level of care criteria

It is a federal requirement for WSCs to make sure that the individual's level of care is reevaluated every 365 days and that they still meet the criteria for institutional care prior to continuing to receive waiver services. The HCBS Waiver Eligibility Worksheet is an important part of this annual process.

The following is a copy of the HCBS Waiver Eligibility Worksheet followed by a description of Handicapping Conditions and Major Life Activities.

HCBS Waiver Eligibility Work Sheet

Name: Suzy Doe	SS#: 123-45-6789
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Region: NORTHEAST	Support Plan Effective Date: 08/01/2018
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I. Level of Care Eligibility:

The individual is an APD client with a Developmental Disability who meets one of the following criteria and is eligible to receive services provided in an ICF/DD. Check the criteria that are met.

Option A. The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 59 or less.

Option B. The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and the individual has at least one of the following handicapping conditions OR the individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.

Option C. The individual is eligible under the category of Autism, Cerebral Palsy, Down Syndrome, Prader-Willi Syndrome, Spina Bifida, or Phelan-McDermid Syndrome and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.

Handicapping Condition			Major Life Activities	
<input type="checkbox"/> Ambulatory Deficits <input type="checkbox"/> Sensory Deficits <input type="checkbox"/> Chronic Health Problems <input type="checkbox"/> Phelan-McDermid Syndrome	<input type="checkbox"/> Behavior Problems <input checked="" type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> Self Care <input type="checkbox"/> Understanding and Use of Language <input checked="" type="checkbox"/> Learning	<input type="checkbox"/> Mobility <input type="checkbox"/> Self Direction <input type="checkbox"/> Capacity for Independent Living

II. Medicaid Eligibility:

A. Individual has a current Medicaid number. Medicaid # 123456789

B. Individual was referred for Medicaid eligibility on:

The result was: Eligible Ineligible Date of Determination:

III. Eligibility Determination: Check the correct statement:

A. Individual has met Level of Care Eligibility (I), has a Medicaid number (IIA), and is eligible for waiver services.

B. Individual has not met the Level of Care Eligibility in I and/or II and, therefore, is not eligible for waiver services.

Support Coordinator (Signature): _____ Date: _____

Agency: _____

IV. Choice: Only to be completed at the time of initial Waiver enrollment and every 365 days thereafter. I have received an explanation of home and community-based services.

(CHOOSE ONE OF THE FOLLOWING)

A. I have been offered waiver services, and I choose to receive community-based supports and services. I understand that I have a choice of enrolled eligible providers.

B. I choose to receive institutional services and prefer services to be provided in an institutional setting.

Individual (Signature): _____ Date: _____

Legal Representative or Witness (Signature): _____ Date: _____

Printed Name of Rep. or Witness: _____ Relationship: _____

* Federal law requires the collection of your social security number as a condition of eligibility for Medicaid benefits under 42 U.S.C. 1320b-7 and the agency will collect, use, and release the number for administrative purposes as authorized under law.

Defining Handicapping Conditions and Major Life Activities

WSCs can use the following information when reviewing eligibility documentation and filling out the HCBS Waiver Eligibility Work Sheet. This information is taken from the proposed Rule 65G-4.17, F.A.C.

To determine whether the applicant meets the level of care necessary to prevent institutionalization, the Agency shall document major life activities and handicapping conditions utilizing all available documentation submitted for review with the application packet and any subsequent evaluation completed for purposes of eligibility determination, including but not limited to: school documents, medical records, comprehensive assessments or evaluations, or through evidence identified in adaptive tests listed in Rule 65G-4.017(6)(d).

(If option B is selected) An applicant for HCBS Waiver whose eligibility determination is based upon a primary diagnosis of Autism, Cerebral Palsy, Prader-Willi Syndrome, Spina Bifida, Down Syndrome, Phelan-McDermid Syndrome, or Intellectual Disability with an IQ two or more standard deviations below the mean but of 60 to 69 must also have at least one handicapping condition or severe functional limitations in at least three major life activities. In addition to meeting the eligibility criteria described in Rule 65G-4.017, F.A.C., the applicant must demonstrate that his or her physical, mental, or behavioral condition meets the criteria described in subsection or of this rule.

In order to constitute a handicapping condition, the following requirements must be met for each respective condition:

Ambulatory Deficits. The person:

- (a) Has a physical and permanent impairment to such a degree that the person is unable to move from place to place without the aid of assistive device; and,
- (b) Cannot compensate for ambulatory deficits by taking breaks or resting while not requiring any assistive device.

Sensory Deficits. The person has trouble receiving and responding to information that comes in through sight, hearing, touch, taste, and/or smell.

Chronic Health Problems. The person experiences an ongoing, chronic medical condition lasting 3 months or more, which generally cannot be prevented by vaccines or cured by medication.

Behavior Problems. The person suffers from a severe behavior disorder, as defined in Rule 65G-4.014(12), F.A.C.

- (a) Autism: The person meets the criteria described in Rule 65G-4.017(4).
- (b) Cerebral Palsy. The person meets the criteria described in Rule 65G-4.017(5).

- (c) Prader-Willi Syndrome. The person meets the criteria described in Rule 65G-4.017(7).
- (d) Spina Bifida. The person meets the criteria described in Rule 65G-4.017(8).
- (e) Down Syndrome. The person meets the criteria described in Rule 65G-4.017(9).
- (f) Epilepsy. The person has been diagnosed by a medical doctor with epilepsy.
- (g) Phelan McDermid Syndrome. The person meets the criteria described in Rule 65G-4.017(10).

In order to constitute a severe functional limitation in a major life activity, the following requirements must be met for each respective major life activity:

Self-Care – The person has severe deficits in their ability to perform basic activities such as eating, toileting, bathing, dressing/undressing, and grooming in the person’s usual living environment in a manner appropriate to age, person, place and setting.

Understanding and Use of Language –The person has severe deficits in their ability to effectively communicate basic wants and needs, follow basic instructions, and/or understand communication from others in a manner appropriate to age, person, place, and setting.

Learning – The person has severe deficits in their ability to acquire, retain, and modify basic functional skills and information that are appropriate to age, person, place and setting.

Mobility – The person has severe deficits in their ability to engage in purposeful movement within each of the person’s usual environments in a manner appropriate to age, person, place, and setting.

Self-Direction – The person lacks or has limited ability to make and follow through with decisions of major consequence and significance to themselves, exercise judgment, set realistic goals, initiate common activities, plan and execute related actions, complete tasks, seek assistance when needed, and evaluate results in a manner, appropriate to age, person, place and setting.

Capacity for Independent Living – The person has severe deficits in their ability to effectively plan and engage in routine activities of daily living in each of his/her usual environments in a manner appropriate to age, person, place, and setting.

WSC Responsibilities in Maintaining Client Eligibility

For clients who are receiving Medicaid benefits, WSCs are responsible for taking steps to ensure that their Medicaid does not lapse. These steps include:

1. **Annually help clients submit the DCF 2515 Form.** When determining and re-determining Medicaid eligibility, the Department of Children and Families requires verification that clients are enrolled on the iBudget waiver. This is documented on the *Certification of Enrollment Status Home and Community Based Services (HCBS)* form, also referred to as the *DCF 2515 Form* (shown below).
2. **Verifying income and assets.** If an individual's total income and assets exceed the amount designated by the SSA, he or she could lose eligibility for Medicaid Benefits. With the individual's permission, the WSC must review his or her personal funds to determine if funds are properly accounted for and are not in excess of the Medicaid asset limit.

In addition to reviewing a client's income, his or her assets must be reviewed to ensure that their total worth does not exceed the amount allowed to maintain Medicaid eligibility.

Examples of assets that should be verified with the individual or their family are:

- Checking and savings accounts, trusts, money market accounts
 - Savings bonds or stocks
 - Life insurance policies
 - Proof of ownership of a vehicle, real property, mobile home, or cemetery lot
3. **Monitor Medicaid eligibility status on a monthly basis.** As a best practice, WSCs should take the time to verify that each client on their caseload has not experienced a lapse in their Medicaid eligibility.
 4. **Identify Medicaid eligibility renewal dates and assist with required paperwork.** Annually, Medicaid eligibility must be renewed, and clients must submit income information to verify continued Medicaid eligibility. To assist with this process, it is a good practice to identify the Medicaid eligibility renewal date for each client on your caseload.

The following is a copy of the *Certification of Enrollment Status Home and Community Based Services (HCBS)* form (or, DCF 2515 form).



CERTIFICATION OF ENROLLMENT STATUS HOME AND COMMUNITY BASED SERVICES (HCBS)

42 CFR 435.910(a) requires each Medicaid applicant to furnish his or her Social Security Number (SSN). The SSN is used to determine eligibility. The SSN may be shared with other programs or agencies involved in the eligibility determination process.

Application

Change

I. Department of Children and Families
Economic Self-Sufficiency Services

II. RE:

Name of Applicant/Recipient

Client Social Security Number

Designated Representative

III. This certifies that the above named applicant/recipient:

- a) was enrolled in the Medicaid waiver (HCBS) on _____
- b) **(For SMMC Long-Term Care waiver only)** Level of Care effective date: _____
(State Medicaid Managed Care)
Level of Care (check one): Skilled Intermediate I Intermediate II
- c) will not be enrolled in the Medicaid waiver (HCBS). (Enter reason below.)

- d) has a change in living arrangement. **(Complete next page.)**
- e) was disenrolled from the Medicaid waiver (HCBS) on _____
- f) died on _____

IV. Case Management Agency: _____

Waiver Program: _____

Mailing Address: _____

Telephone Number (include area code): _____

V. **If the above named applicant/recipient is enrolled in waiver services, you must report any changes to DCF/Economic Self-Sufficiency Services staff immediately.**

VI. Certified By:

Case Manager's Name (Print)

Case Manager's Signature

Date

**CHANGE IN HCBS RECIPIENT'S LIVING ARRANGEMENT
UPDATE INFORMATION**

VII. LIVING ARRANGEMENT INFORMATION:

- a) Previous address: _____
- b) New address: _____
- c) Effective date of new address: _____
- d) Note type of living arrangement: (e.g., assisted living facility (ALF), hospital, living in the community, etc.)

- e) For ALFs only – Customary Room and Board Rate Amount: \$ _____

VIII. CASE MANAGER COORDINATION CHECKLIST:

- a) Has a current DCF eligibility specialist been notified? NO YES (date): _____

NOTE: Do not complete the following section unless the above change in the HCBS recipient's address results in a change in Case Management Agency.

IX. NEW CASE MANAGER INFORMATION:

- a) Recipient transferred to another Medicaid waiver Case Manager on (date): _____

Case Management Agency: _____

Contact Person: _____

Mailing Address: _____

Telephone Number (include area code): _____

Additional Reading:

More specific information on how an individual applies for Medicaid benefits can be found at the DCF website at: myflfamilies.com/service-programs/access/

What do you do if a person's Medicaid Eligibility is terminated?

If one of your clients loses their Medicaid eligibility, the following steps must be taken immediately:

1. Notify the APD regional office and work with them to plan for alternative funding sources.
2. Notify all providers. If a person is not eligible for Medicaid, they are not eligible for APD services. In this case, all service authorizations for that person will be rejected by the Medicaid billing system.
3. Work with the individual right away to take the necessary steps to reinstate their Medicaid benefits reinstated.
4. Upon reinstatement of Medicaid, the WSC must re-submit a service authorization to each provider.

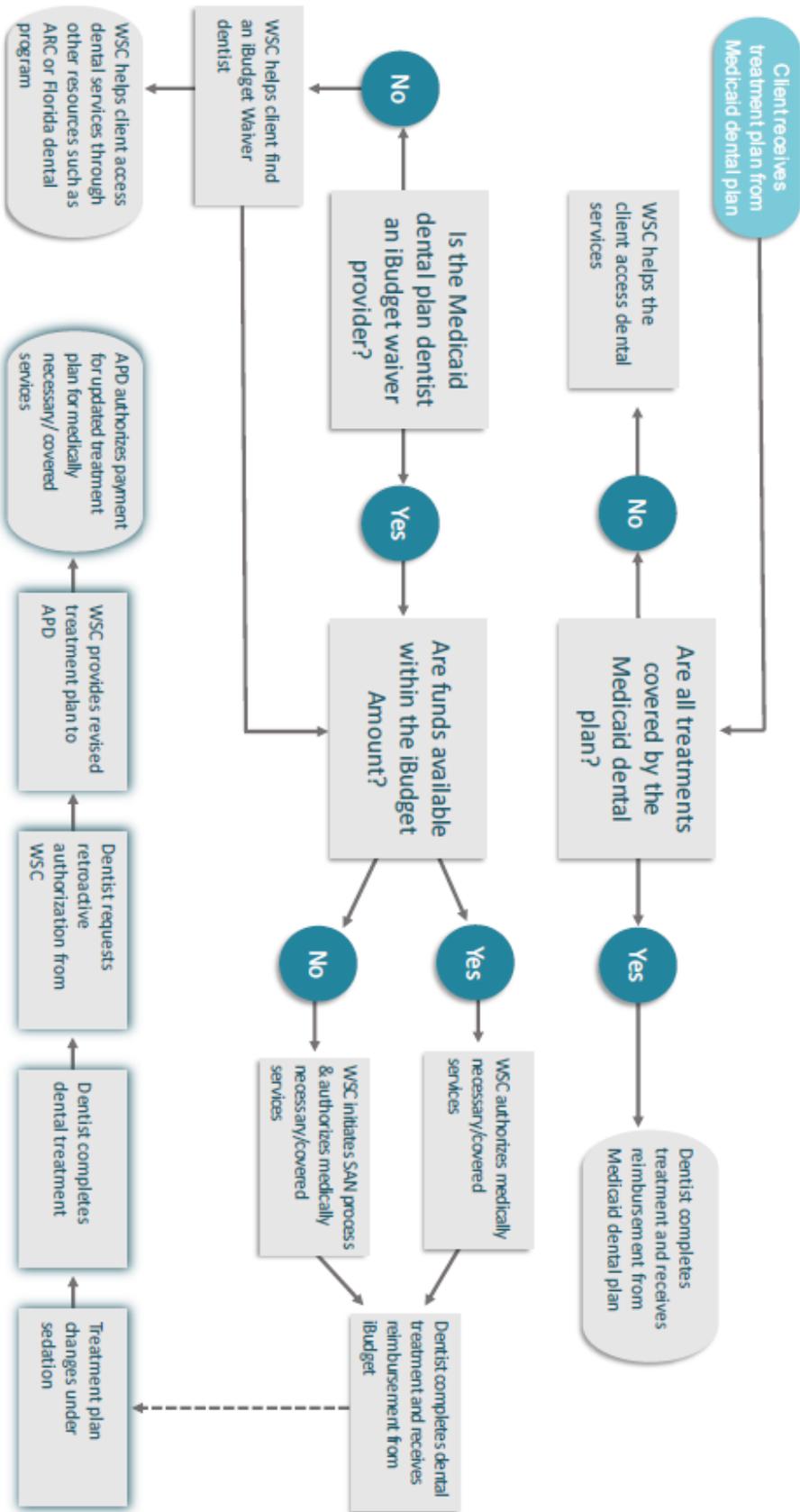
Medicaid Programs and Services

While most of your focus as a Waiver Support Coordinator will be on assisting your clients in accessing waiver services in addition to community resources, there are many Medicaid services that are available to the clients you'll be serving. You will have an important role in helping them access those services.

The APD clients you serve, including children under the age of 21, have the option to utilize either a managed care plan or the traditional fee for service Medicaid program. It's important to know which program your clients have chosen. However, dental managed care is not optional.

The following is a helpful tool called *Adult Dental Services for Clients Enrolled on the iBudget Waiver Flow Chart*.

Process Flow – Adult Dental Services for Clients Enrolled on the iBudget Waiver – 8/19/19



If WSCs or providers have questions related to the Medicaid dental plan, the following contacts are available for assistance:

- **DentaQuest:** 1-888-468-5509, TDD: 1-800-466-7566, Website: dentaquest.com/state-plans/regions/florida/
- **Liberty:** 1-833-276-0850, TDD: 1-877-855-8039, Website: libertydentalplan.com/FLMedicaid
- **MCNA:** 1-855-699-6262, TDD: 1-800-955-8771, Website: mcnafl.net

For additional assistance in selecting an appropriate managed care plan, the WSC should assist the individual in contacting a Choice Counselor for help by calling **1-877-711-3662**.

The Quality Improvement Organization (QIO)

The Agency for Health Care Administration has contracted with a certified Quality Improvement Organization (QIO) to provide medical necessity reviews for Medicaid home health services, such as consumable medical supplies.

The purpose of the QIO is to:

- Determine medical necessity of services and supplies requested
- Prevent unnecessary or inappropriate provision of Medicaid services
- Provide service authorizations and legal notices that clearly show which services are approved, denied, or terminated.

EPSDT Special Services Request for iBudget Waiver Individuals Under the Age of 21

Based on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, all items that are medically necessary for clients under age 21 must be made available through Medicaid State Plan. There are some items, such as wipes, that are not a specifically listed item in Medicaid Policy, and for this items the WSC must assist in submitting a special services request using a miscellaneous code.

The following is a summary of the process:

1. While it is the actual provider or “vendor” that sends in the request, the WSC should assist with gathering documentation. Supporting documentation may include:
2. Physician order (with NPI and physician signature)
3. Clinical documentation supporting the medical necessity of the request
4. Cost of the supplies
5. Please note - supporting documentation cannot be more than 1 year older than the date of the request
6. The individual’s DME provider (Vendor) completes the Multi-Specialty Services Prior Authorization Request form found at the QIO’s website.
7. An authorization number to be used on claims for reimbursement will be created in Florida Medicaid Managed Information System (FMMIS) for approved requests.

Personal Care Assistance and Behavior Analysis Services through Medicaid

The Florida Medicaid program through the Agency for Healthcare Administration (AHCA) provides personal care assistance and behavior analysis services to Medicaid eligible individuals who are under the age of 21 when medically necessary.

Helpful resources for accessing Medicaid PCA services:

- The Florida Developmental Disabilities Council has a publication entitled, *Accessing Home Health Care, Nursing, and Personal Supports for Individuals Who Receive Florida Medicaid and iBudget Services*. This publication contains a summary of home health services that may be helpful.
- Florida Health Finder is an AHCA site that provides multiple healthcare related links and consumer guides. There is also a link where clients can search for home health providers.
- Medicaid has a toll-free number for clients if they are having problems accessing care. The Medicaid Helpline can be reached by calling 1-877-254-1055.

APD Technical Assistance Document
 Services/Potential Resources Available to Individuals with Developmental Disabilities who are Medicaid Eligible

Age	AHCA Medicaid State Plan	APD	DCF Foster Care	DOE - Public School	DOH / Children's Medical Services
5-22 years	Same as above, up to age 21.	Under 21 – same as above Age 21 and over, see below. Personal Supports and Supported Living can begin at age 18 when a person lives in their own home (supported living arrangements). Supported Employment Services are available prior to age 22 if the individual has graduated from the public school system and exhausted Vocational Rehabilitation resource etc.	Same as above Additional Services <ul style="list-style-type: none"> Extended Foster Care Program - Ages 18-21 Temporary Aftercare Services Road to Independence Program 	<ul style="list-style-type: none"> Education and related services up to the age of 22 if the individual does not have a standard high school or GED diploma Vocational Rehabilitation/Employment Services (when preparing for transition or graduation from high school) 	Children's Medical Services Plans as listed above until age 21.
22 and up	Statewide Medicaid Managed Care Program Statewide Managed Care Dental Program Limited Fee for Service Medicaid Physical Therapy up to \$2500 Respiratory Therapy up to \$1500 Skilled Nursing Dentures Respiratory Supplies Toucheconomy Supplies External Formulas and Medical Supplies Medical – physician services Home Health – limited Consumable Medical Supplies Durable Medical Equipment Prescribed Drug Services ICF/IID Nursing Facility Transportation Hospital Services MMA – voluntary (provides expanded services for adults)	Available based on medical necessity criteria and need: <ul style="list-style-type: none"> • Waiver Support Coordination • Consumable Medical Supplies • Durable Medical Equipment • Adult Dental • Nursing • Therapies (Occupational, Speech, Physical, Respiratory) • Transportation • Specialized Mental Health Counseling • Dietician Available based on medical necessity criteria and living setting: <ul style="list-style-type: none"> • Family Home - • Personal Supports • Life Skills Development (Supported Employment, Adult Day Training, Community) • Environmental Accessibility • Adaptations • Personal emergency response system • Behavior Analysis and Assistant 		Vocational Rehabilitation employment services	

APD Technical Assistance Document
 Services/Potential Resources Available to Individuals with Developmental Disabilities who are Medicaid Eligible

Age	AVCA Medicaid State Plan	APD	DC: Foster Care	DC: Public School	DOH / Children's Medical Services
22 and up (look forward)		<p>Own Home/Supported Living –</p> <ul style="list-style-type: none"> • Personal Supports • Supported Living Coaching • Life Skills Development (Supported Employment, Adult Day Training, Companion) • Environmental Accessibility • Adaptations • Personal emergency response system • Behavior Analysis and Assistant <p>Community-based/licensed residential facility –</p> <ul style="list-style-type: none"> • Residential Habilitation • Life Skills Development (Supported Employment, Adult Day Training, Companion) • Special Medical Home Care • Behavior Analysis and Assistant <p>Unfunded services as described above may be available through individual and family support services (IFS) funding for individuals on the waiting list or other APD clients when needed.</p>			

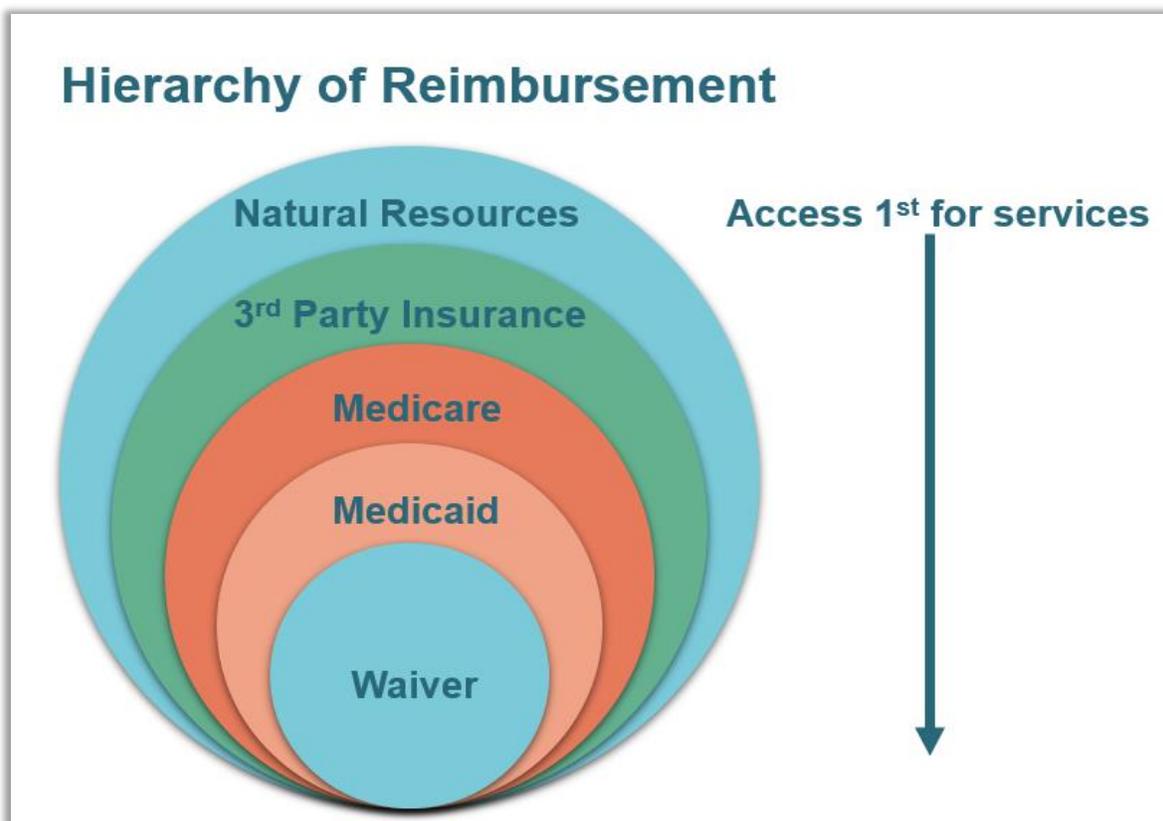
If you work with someone who is having trouble accessing Medicaid services:

Contact the AHCA complaint hub to address these issues.

You can submit a complaint by calling 1-877-254-1055 or online at ahca.myflorida.com/Medicaid/complaints/index.shtml.

Hierarchy of Reimbursement

The hierarchy of reimbursement (shown below) should guide how services are accessed for your clients. This includes natural resources, third-party insurance, Medicare, Medicaid, and then the APD waiver. A phrase you may have heard is, “The waiver is the payor of last resort”. This means funding for services from other sources must be exhausted first, before seeking services for the same needs through the waiver.



The following is a WSC Advisory providing information on Therapies available through Medicare Plan B.

WSC ADVISORY #2018-016
MEDICARE PART B THERAPY COVERAGE

ACTION REQUIRED

EFFECTIVE DATE: MAY 22, 2018

This advisory is to inform Waiver Support Coordinators (WSCs) about the availability of Physical Therapy, Occupational Therapy, and Speech Therapy services through Medicare. Medicare law no longer limits how much Medicare pays for the medically necessary Physical, Occupational, and Speech Therapy services in one calendar year. Therefore, there is no longer the therapy cap dollar limit. However, the therapist will need to add information to the claim confirming the service is medically necessary if services reach \$2,010 for physical and speech therapy combined and \$2,010 for occupational therapy

WSCs who serve consumers who need therapies and are Medicare eligible, must access the therapies through Medicare prior to accessing Waiver funding.

To assist in accessing these therapies through Medicare, the WSC must:

- Check the client's Medicare Part B eligibility, and renew it if necessary
- Ensure the doctor or therapist is a participating provider and request that the billing is completed through Medicare Part B
- If submitting a request for iBudget funded therapy services, the WSC must provide documentation of attempts to access the services through Medicare and why the services are not available.
 - This may include a denial from Medicare or case notes/narrative information of the attempts made to access the service, names of providers contacted, dates, and the outcome.

The Developmental Disabilities iBudget Waiver Handbook Rule 59G-13.070, F.A.C., page 2-13 states:

"Services must not be authorized under the iBudget Waiver if they are available from another source. It is the WSC's responsibility to first ensure that the same type of service offered through the waiver cannot be accessed through other funding sources, such as:

- Natural and community supports.
- Third Party Payer (e.g., private insurance).
- Medicare.
- Other Medicaid programs (e.g., Medicaid State Plan or Medicaid managed care plan).

If a recipient is dually-eligible under Medicare and Medicaid, the WSC must secure services from providers enrolled as Medicare and Medicaid providers so that any services that are covered by Medicare can be billed to Medicare first before billing to Medicaid (e.g., Medicaid cannot reimburse a non-Medicaid home health agency for Medicare reimbursable services provided to a dual-eligible recipient)."