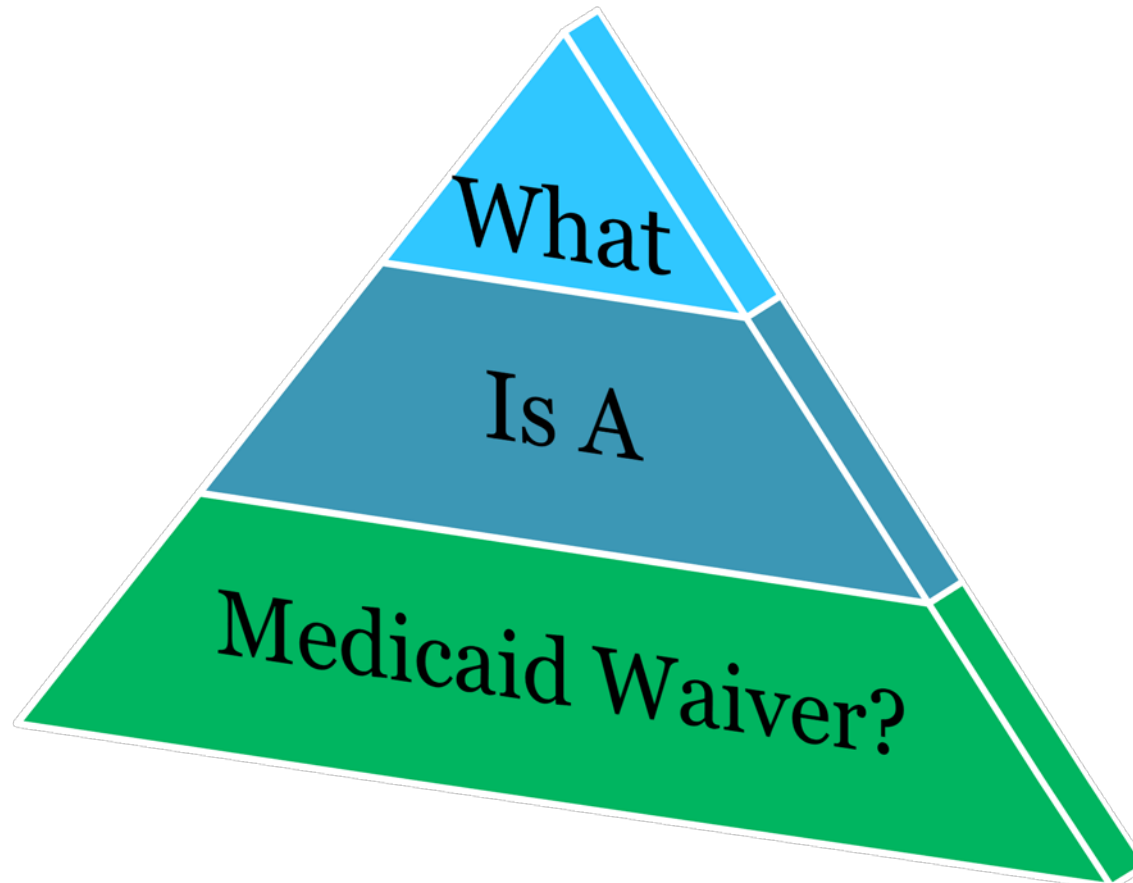



Medicaid Home and Community-Based Waiver 101




Improving lives THROUGH supports and services THAT FOSTER self-determination.




Centers for Medicare and Medicaid Services (CMS)

-  A federal government agency under Health & Human Services (HHS) that assists in providing health coverage through the Medicare, Medicaid and Children's Health Insurance Program (CHIP).


Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID)

-  An optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. ICF/ID is only available for individuals in need of, and receiving active treatment.


Medicaid Waivers

-  CMS and state partnerships that allow states the opportunity to test new or existing ways to deliver and pay for health care services. There are four types of waivers, DDD only uses the 1915(c) home and community-based waiver.

1915 (c) Home and Community-Based Waiver

-  Allows states to deliver long-term care services in home and community settings rather than institutional settings like nursing homes and ICF/ID. CMS codified home and community based settings requirements in 42 CFR 441.301

SB40 Board

-  SB40 (1969) allowed counties to pass a tax on personal property to support services for individuals with a developmental disability. Tax dollars generated are managed by a nine member public board in the county.

History of Medicaid Waiver

President Lyndon Johnson signed Medicare and Medicaid into law in 1965.



Former President Harry Truman received the first Medicare card.



Medicaid's purpose is
'to furnish rehabilitation and other services to help such families and individuals attain or retain capability for independent or self care'

People with developmental disabilities originally had to live in habilitation centers (hospital like settings) to receive funding.



History of Medicaid Waiver

The Omnibus Budget Reconciliation Act of 1981 added a new section to the Social Security act, Section 1915 (c), authorizing state Medicaid agencies to apply for home and community based waivers.

People no longer had to live in institutions in order to receive Medicaid – they could take those dollars into the community.

Missouri's first waiver for people with developmental disabilities was implemented in 1988.

Medicaid funding in MO consists of matching approximately 36 percent state general revenue dollars with approximately 64 percent federal dollars.

The Partnership for Hope waiver, approved by CMS, was created with a new funding stream where the SB40 pays 18 percent of the match and the state pays 18 percent of the match.

What is a 1915(c) waiver?

- 👤 Arrangement between the state and federal government that allows the state to use Medicaid funding for specialized services provided only to a target group of people and not to all people with Medicaid eligibility.
- 👤 DDD waiver service is for a targeted group of individuals who have developmental disabilities who have otherwise been served in an ICF/ID.
- 👤 Within 1915(c) parameters, the state determines:
 - 👤 The number of people served;
 - 👤 What services are covered;
 - 👤 How much it will spend on services in each waiver.

Waiver Cost Neutrality



- ❶ §1915(c)(2)(D) of the Act requires the average per capita expenditure under the waiver during each waiver year not exceed 100 percent of the average per capita expenditures that would have been made during the same year for the level of care provided in a hospital, nursing facility, or ICF/IID under the State plan had the waiver not been granted.

Waiver Cost Neutrality

- 🕒 The equation set forth in 42 CFR §441.303(f)(1) specifies the components of the cost neutrality demonstration. This equation is:

$$\mathbf{D+D' \leq G+G'}$$

- 🕒 **D** = the estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.
- 🕒 **D'** = the estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program. (State Plan)
- 🕒 **G** = the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/IID care that would be incurred for individuals served in the waiver, were the waiver not granted.
- 🕒 **G'** = the estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted. (State Plan)

Eligibility for the Division of DD Waivers



- 👤 Be eligible for MO Division of Developmental Disabilities
- 👤 Be MO HealthNet (Medicaid) eligible as determined by Missouri Family Support Division.
- 👤 Evaluation of Need for ICF/ID Level of Care (LOC):
 - 👤 Meet the federal definition of developmental disability (three substantial functional limitations), and
 - 👤 Have active habilitation needs, and
 - 👤 There is reasonable indication that the individual has needs that could be met with ICF/ID services unless provided Home and Community Based Services under the Waiver
- 👤 ICF/ID LOC determined initially and at least every 365 days from the initial date

Waiver Operational and Administrative Functions



- 🕒 **Participant waiver enrollment.** This function includes performing waiver intake activities, including taking applications to enter the waiver and referring, when necessary, individuals for the determination of Medicaid eligibility and/or disability.
- 🕒 **Waiver enrollment managed against approved limits.** This function includes ensuring that the waiver's participant limit is not exceeded and managing entrance to the waiver by applying the state's policies concerning the selection of individuals to enter the waiver. The function also might include establishing and maintaining a waiting list for entrance to waiver, if necessary. When waiver capacity is allocated by locality or region, local/regional non-state agencies may also be involved in managing enrollment.
- 🕒 **Waiver expenditures managed against approved levels.** This function includes monitoring waiver expenditures to assure that the waiver is cost neutral and operates within the estimates in the approved waiver. Per person cost of waiver participants must be less than the per person cost of individuals in an institution.

Waiver Operational and Administrative Functions cont'd



- 🕒 **Level of care evaluation.** Activities may include compiling the necessary information to evaluate potential entrants to the waiver and the continuing need for the level of care that the waiver provides for waiver participants.

- 🕒 **Review of participant service plans.** This activity may include local/regional entity review of service plans or, if required by the state, the review and approval of service plans by the Medicaid agency or the operating agency. The focus is on activities that take place once a service plan has been developed but prior to its implementation.
 - 📌 Note: This function does not include the retrospective review of service plans that might be conducted by the Medicaid agency in order to (a) meet the requirement that service plans are subject to the approval of the Medicaid agency or (b) determine retrospectively whether service plans appropriately address the needs of waiver participants, a quality improvement activity that is addressed in the State's QIS.

- 🕒 **Prior authorization of waiver services.** The review of the necessity of specific waiver services before they are authorized or delivered. It does not refer to review of the overall service plan.

Waiver Operational and Administrative Functions cont'd



- 📍 **Utilization management.** Includes processes to ensure that waiver services have been authorized in conformance to waiver requirements and monitoring service utilization to ensure that the amount of services is within the levels authorized in the service plan or that services utilized have been authorized in the service plan. It also may include identifying instances when individuals are not receiving services authorized in the service plan or the amount of services utilized is substantially less than the amount authorized to identify potential problems in service access.
- 📍 **Qualified Provider enrollment.** Qualified provider enrollment refers to the performance of standard provider enrollment processes conducted by the State Medicaid Agency, as well as any delegated functions related to the recruitment and enrollment of providers.
- 📍 **Execution of Medicaid provider agreements.** §1902(a)(27) of the Act and 42 CFR §107 require that there be an agreement between the Medicaid agency and each provider that furnishes services under the waiver.

Waiver Operational and Administrative Functions cont'd



- 📍 **Establishment of Statewide Rate Methodology.** States must have uniform and consistently applied policies concerning the determination of waiver payment amounts or rates.
- 📍 **Rules, policies procedures and information development governing the waiver program .** This function includes the development of any rules, policies and procedures that govern administration of the waiver. While other entities may be involved in the development of these items, the State Medicaid Agency must retain ultimate approval authority and they must be consistent in all jurisdictions in which the waiver operates.
- 📍 **Quality assurance and quality improvement activities** This function refers to the activities related to discovery and remediation activities conducted for the waiver, as well as the mechanisms for overall systems improvement.

State Plan

MO HealthNet Services

Before waiver services are authorized, first must ensure that state plan MO HealthNet services are accessed when those services can meet the individual's need.

Examples of State Plan services:



- ✓ Doctor's Office visits
- ✓ Durable medical equipment
- ✓ Personal care
- ✓ Pharmacy
- ✓ Hospital
- ✓ Home health care, etc.
- ✓ Therapies



Early and Periodic Screening, Diagnostic, and Treatment

- 👤 In 1967, Congress introduced Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for children under the age of 21 enrolled in Medicaid.
- 👤 States are required to provide comprehensive services and furnish all Medicaid age-appropriate screening, preventive services, and treatment services that are medically necessary services needed to correct and ameliorate health conditions under EPSDT. EPSDT is made up of the following services:
 - 👤 Screening Services
 - 👤 Vision Services
 - 👤 Dental Services
 - 👤 Hearing Services
 - 👤 Other Necessary Health Care Services
 - 👤 Diagnostic Services
 - 👤 Therapies

Core 1915 (c) Waiver Services

Core Waiver Services

complement
State plan
services

Must specify the scope and nature of each waiver service and any limits on amount, frequency and duration

Must specify qualifications of the individuals or agencies that furnish each waiver service

(a) statutory services;
(b) other services;
(c) extended state plan services; and,
(d) services in support of participant direction.

May modify or supplement the core definition in order to more precisely reflect the nature and scope of each service included in a waiver

If propose an alternate definition, each service must be fully described and not described in open-ended terms

Alternate definitions will be reviewed by CMS to determine whether the scope and nature of the service as defined is consistent with waiver service coverage policy



Core 1915(c) Waiver Services

Statutory Service

Specifically contained in §1915(c) of the Act and 42 CFR §440.180. A waiver is considered to cover a statutory service as long as the state's definition aligns with the core service definition included here, even though an alternate title is used (e.g., support coordination instead of case management or attendant care instead of personal care)

Other Services

Services beyond those that are included here. When coverage of another service is proposed, CMS will review the proposed coverage to ensure that the service is necessary in order to avoid institutionalization and addresses participant needs that stem from their disability or condition.

Extended State Plan Services

exceed the limits that apply under the State plan.

Self-Direction

participant (or the participant's representative) may direct and manage some or all of their waiver services. The state is expected to make supports available to the participant as necessary to facilitate participant direction.

Core 1915(c) Waiver Services



📍 **Statutory Services:**

- 📍 Case Management
- 📍 Home Maker Services
- 📍 Home Health Aide Services
- 📍 Adult Day Health
- 📍 Habilitation
- 📍 Residential Habilitation
- 📍 Day Habilitation
- 📍 Education
- 📍 Prevocational Services
- 📍 Individual Supported Employment
- 📍 Small Group Supported Employment
- 📍 Respite Care
- 📍 Mental Health Services
- 📍 Day Treatment
- 📍 Psychosocial Rehabilitation Services
- 📍 Clinic Services (Extended State Plan)
- 📍 Live In Caregiver

📍 **Other Services:**

- 📍 Home Accessibility Adaptations
- 📍 Vehicle Modifications
- 📍 Non-Medical Transportation
- 📍 Specialized Medical Equipment and Supplies
- 📍 Assistive Technology
- 📍 Personal Emergency Response System
- 📍 Community Transition Services
- 📍 Skilled Nursing
- 📍 Private Duty Nursing
- 📍 Adult Foster Care
- 📍 Assisted Living Services
- 📍 Chore Services
- 📍 Adult Companion Services
- 📍 Training and Counseling Services for Unpaid Caregivers
- 📍 Consultative Clinical and Therapeutic
- 📍 Individual Directed Goods and Services
- 📍 Bereavement Counseling
- 📍 Career Planning

CMS Review of Services

Each service is separately defined

Does not duplicate coverage under the State plan, including EPSDT Coverage

Definition clearly delineates the purpose and the scope of the service

Service does not span multiple, unrelated services, although similar or related services may be combined

When the scope of a service potentially overlaps with the scope of another service, there are mechanisms that prevent duplicate billing

CMS Review of Services

Non-statutory services are necessary to avoid institutionalization and address functional impairments that if left unaddressed, would prevent the person from engaging in daily community activities.

Any limits on the amount, duration and frequency for the service are consistent with assuring health and welfare for the target population

Provider qualifications are specified for each service and are appropriate to the nature and type of the service

Provider qualifications include requirements for training, experience and education that are sufficient to ensure that waiver participants will receive services in a safe and effective manner

Provider qualifications do not include requirements that would unnecessarily restrict the number of providers, including unnecessarily restricting the provision of a service to agency providers

Rate Determination

- 🕒 Waiver payment rates may be determined in a variety of ways and frequently the methods that are employed vary by type of service.

- 🕒 All rate determination methods must be consistent with the provisions of §1902(a)30(A) of the Act (i.e., “payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers”) and the related Federal regulations at 42 CFR §447.200-205. The state should have a monitoring process to ensure that these requirements are met.

- 🕒 Rates may be prospective or provide for retrospective cost settlement of interim rates.
 - ⚠️ Rates may be established by maintaining a state established fee-for-service schedule.
 - ⚠️ Rates may incorporate “difficulty of care” factors to take into account the level of provider effort associated with serving individuals who have differing support needs;
 - ⚠️ rates may also include geographic adjustment factors to reflect differences in the costs of furnishing services in different parts of a state.
 - ⚠️ for participant direction, identify whether a rate determination is used that in any way differs from the methodology used when the service is provider-managed. State laws, regulations or policies cited in this description must be readily available through the State Medicaid agency or the operating agency (if applicable) when requested by CMS

CMS Rate Review Criteria

Describes the rate setting method that it used for *each* waiver service. If rates are not uniform for every provider of a waiver service, the waiver describes the basis for the variation

Specifies the entity (or entities) responsible for rate determination and how oversight of the rate determination process is conducted.

Describes how the Medicaid agency solicits public comments on rate determination methods.

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Waiver Assurances (Required by CMS)

- 📍 **The state is expected to have, at the minimum, systems in place to measure and improve its performance in meeting the waiver assurances that are set forth in 42 CFR §441.301 and §441.302.**
 - 👤 These assurances address important dimensions of waiver quality, including assuring that service plans are designed to meet the needs of waiver participants and that there are effective systems in place to monitor participant health and welfare.
- 📍 Continuation of a waiver is contingent on CMS determining that the state has satisfactorily met the waiver assurances and other Federal requirements, including the submission of mandatory annual waiver reports (the CMS-372(S) report).
- 📍 Office of Inspector General (OIG) may also audit waivers retrospectively.

Waiver Assurances (Required by CMS)

1 Level of Care

2 Service Plans


3 Health and Welfare


4 Financial Accountability


5 Administrative Authority

Level of Care (LOC) – Waiver Assurance



- 
- An evaluation for LOC is provided to all applicants

- 
- The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver

- 
- The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care

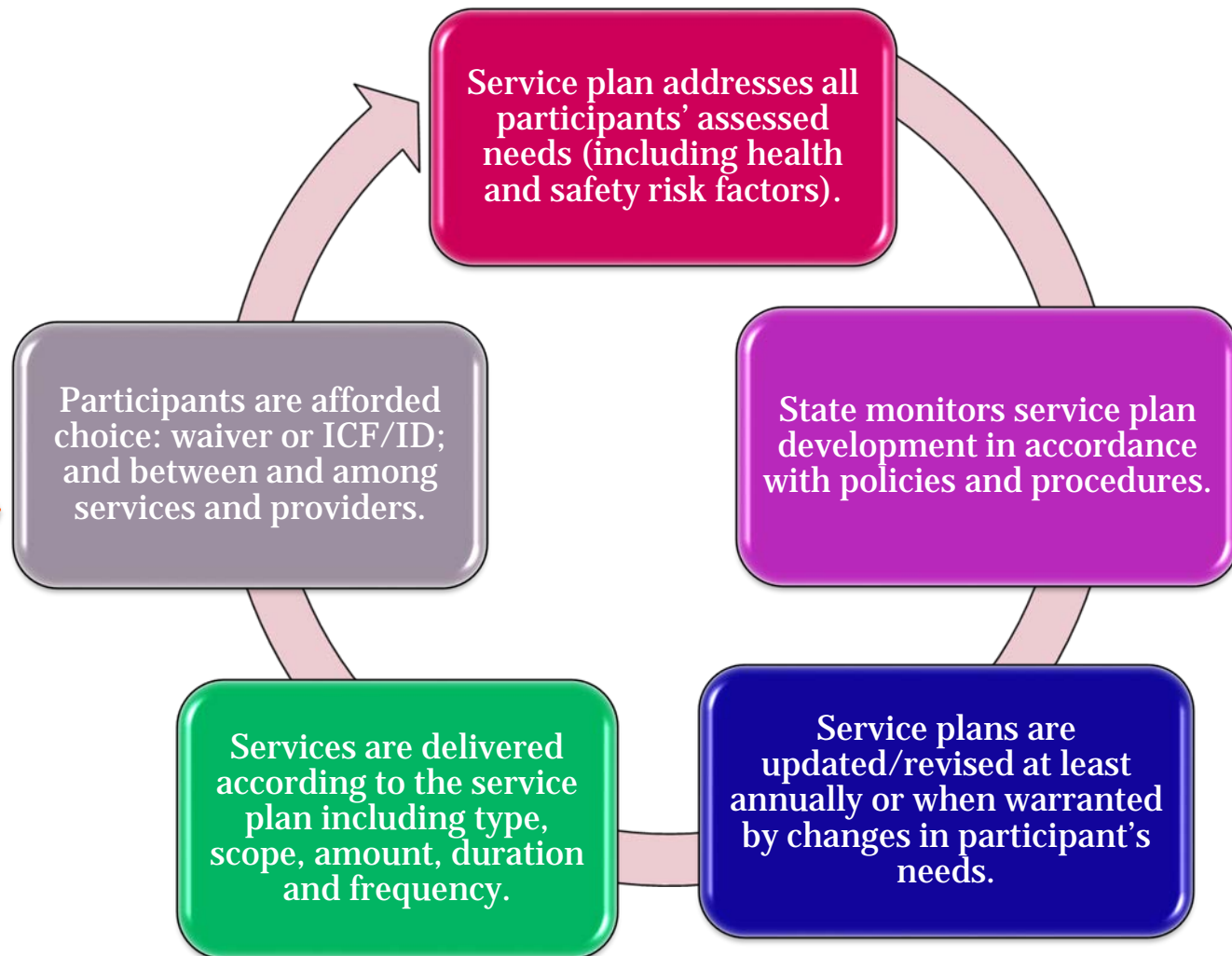
Service Plans

– Waiver Assurance



Who might be involved in service planning:

- *Individual*
- *Parent*
- *Guardian*
- *Support Coordinator*
- *Providers*
- *Natural Supports*
- *Neighbors*
- *Friends*
- *Other family*



Provider Qualifications

– Waiver Assurances



- 🕒 License or Certification either from DMH or from a professional accreditation organization
- 🕒 Professional license, if applicable
- 🕒 Completed appropriate training, as determined by the department and the individual's planning team
- 🕒 Guarantee appropriate supervision of staff
- 🕒 Cannot be individual's spouse, parent (if a minor child) or legal guardian

Waiver Assurances

Health and Welfare

- ❖ State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.
- ❖ Adequate standards for all types of providers.

Financial Accountability

- ❖ State financial oversight exists to assure claims are coded and paid in accordance with reimbursement methodology specified in the approved waiver.

Administrative Authority

- ❖ Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies and contracted entities.

RESOURCES

Guidelines

<http://dmh.mo.gov/dd/guidelines.html>

Provider Manual

<http://dmh.mo.gov/dd/manuals/waivermanuals.html>

Federal Programs Page

<http://dmh.mo.gov/dd/progs/>



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THAT FOSTER self-determination.

Questions?