



Key Concepts Regarding the Waiver

January 15, 2014

What is a waiver?

- ❖ A waiver means that the regular rules are “waived”—that is, regular rules are not applied.
- ❖ The Home and Community Based (HCBS) waiver began in 1981 as a means to correct the “institutional bias” of Medicaid funding. North Dakota started their Autism waiver in 2010 to meet the unique needs of individuals with autism.
- ❖ The “bias” noted above is that individuals could get support services while institutionalized, but if they wanted to remain or live in the community they could not get similar services.
- ❖ Section 1915 c of the Social Security Act was changed to allow states to ask for waivers.
- ❖ The idea is that states can use the Medicaid money for community services that would have been used if the person went to an institution.
- ❖ **Thus getting HCBS waiver services is tied to institutional eligibility.**
- ❖ This does not mean that you have to go to an institution or want to go to an institution - ---just that you could be eligible for services in an institution.

Benefits of a Waiver:

- ❖ People can choose services in the community where they can live with family and friends.
- ❖ The state and stakeholders can decide:
 - The values that underlie our system
 - What supports and services are covered and
 - Who can provide those services
- ❖ Medicaid is a matching program where the STATE pays part of the cost (based on a formula) and the FEDERAL government “matches” what the state pays.
 - This is important because the availability of STATE money drives how many people the waiver can serve and how much a state spends. The waiver must operate based on the spending/budget that is designated by the Legislature.

Waiver application:

- ❖ Back in the good old days there was no waiver application, just a set of statutes.
- ❖ In 1990 CMS (Centers for Medicaid/Medicare Services) published a waiver template that was about 24 pages. In 1995 a new version was published that was about 35 pages.
- ❖ After a the General Accounting Office completed a review of HCBS waivers and severely criticized CMS (formerly HCFA) and their oversight of the waivers, we now have 324

page guide to filling out the CMS application which is about 100 pages when blank with 10 appendices.

- ❖ The Centers for Medicare and Medicaid Services (CMS) provides states with an application to fill out. It is called the waiver format or template. The state fills in the template and submits the plan to CMS.

Appendix A –Waiver Administration and Operation- explains who is operating the waiver, who has oversight of the waiver, any contracted entities (fiscal agent\Acumen) and assessment methods of the entities.

- The State Medicaid agency must retain oversight over all aspects of the Waiver.
- Autism Services Unit has day to day responsibility for operation.
- No changes

Appendix B – Participant Access & Eligibility – explains who the waiver is serving, costs to the individual if any, number served, reserved capacity if any, eligibility groups and evaluation & reevaluation of LOC (Level of Care)

- Slots – Originally set in the Autism Waiver at 30 participant slots – did not change reserved capacity until the 2012/2013 legislative session approved 17 additional slots.
 - Year 1 30 slots
 - Year 2 30 slots
 - Year 3 30 slots
 - Year 4 Increasing to 47 slots
 - Year 5 Increasing to 47 slots
- New Performance measures

❖ **Key concepts in Appendix B:**

- **Who can receive an ASD waiver service?**
 - The person must be eligible for Medicaid, according to your state rules
AND
 - Meet what's called the level of care (LOC) for:
 - Nursing Home
 - ICF/IID
 - Hospital or
 - Other Medicaid-financed institutional care
- The State must select **one** of the three principal target groups and for the target group selected, may select one more of the subgroups listed.
 - Aged (persons age 65 and older) or disabled; or both;
 - Persons with mental retardation or a developmental disability or both;
 - Persons with mental illnesses.

- The waiver we are referring to is persons with an “intellectual disability or a developmental disability”. The state selected both options. The ICF/IID level of care must be met in order to participate.
- Individuals who are in the waiver target group AND would otherwise require the Medicaid covered level of care specified for the waiver may be considered for entrance to the waiver. Both conditions must be met.

Mental retardation or Developmental Disability group – this target group is composed of individuals who otherwise would require the level of care furnished in an ICF/MR which is defined as serving persons with mental retardation or persons with related conditions. States are advised that the ICF/IID level of care is reserved for persons with mental retardation (intellectual disability) or a related condition as defined in 42 CFR 435.1009 . Participants linked to the ICF/IID level of care must meet the “related condition” definition when they are not diagnosed as having an intellectual disability. While “Developmental Disability” and “Related Conditions” overlap, they are not equivalent. The definition of related conditions is at 42 CFR 435.1009 and is functional rather than tied to a fixed list of conditions.

Appendix C –

Appendix C – Participant Services- summary of all the services, any service limitations, and provider requirements

- Environmental Modifications AND Equipment & supplies: changed to Assistive Technology in the Autism Waiver
- In Home Supports: Changed to Respite Care in the Autism Waiver– Added the following limitations:
 - Respite care is not authorized when Part B services of IDEA (Individuals with Disabilities) Education Act) offered through the North Dakota Department of Public Instruction are available to the participant. (Clarification)
 - Respite care is not authorized when Day Support or Extended services are available to the participant. (Clarification)
 - A Respite care participant cannot be authorized to receive both provider managed and self-directed at the same time. (Clarification)
 - Respite care is limited to 60 hours per month or less, based upon the Level of Care determination. *Rare* exceptions may be granted by the Autism Services Division to ensure health & welfare and to avoid institutionalization.
 - Payments will not be made for the routine care and supervision which would be expected to be provided by a family for activities or supervision for which a payment is made by a source other than Medicaid. (CMS required language from the Autism waiver renewal (2013).)
- New Performance measures

Appendix D – Participant-Centered Planning & Service Delivery explains the participant development of the service plan, implementation, and monitoring of the plan

- New performance measures

❖ **Key concepts in Appendix D**

- Waiver requirement that everyone has an individual plan of care developed by qualified individuals.
- Participant’s legal guardian can determine who participates in the process and they can direct the process.
- The plan must be reviewed at least annually or when the individual’s needs change.
- Must address risks and risk management strategies in the plan including emergency back up plans.

Appendix E – Participant Direction of Services explains in the waiver how participant’s legal guardians can self-direct their services, what services are self-directed, and whether or not a third party is involved, explains Service Managers as an administrative activity, termination of self-directed services, budget authority of these services.

Appendix F- Participants Rights— explains a participant’s opportunity for a fair hearing, disputes resolutions, grievances, and complaints

- updated the policy & procedures for fair hearing requirements and participant’s rights

❖ **Key concepts in Appendix F:**

- Freedom of choice of providers – People can choose any provider they want that is qualified, under state rules, to do the work.
- Appeal rights when a service is denied, suspended, terminated or reduced.

Appendix G- Participants Safeguards – explains what the state will do with A, N, E (Abuse, Neglect, and Exploitation) and management of medication administration (how reported, when to report, what to report, oversight, interventions, and safeguards)

- creating the policy current policy and procedures for A, N, E
- Requiring provider to submit an annual report to the Autism Services Unit identifying participants who have restrictive intervention in the participant’s service plan.
- Reviews of data are compiled and reviewed at least quarterly by the service provider responsible for implementation of the plan. The service manager reviews the use of individual restrictive interventions during the Quality Enhancement Review (QER) to assure the safeguards and requirements are met and to assure that the approval of the individual/legal decision maker, behavior management committee and the Human Rights Committee is documented. This information is recorded in the QER and any noncompliance or needed follow up regarding the use of restrictive interventions are initiated and documented.
- New performance measures

- **Key concepts in Appendix G:**

- The State must have a formal system to monitor health and safety
- State oversight of the service system with providers through visits
- Collecting data on system performance and waiver assurances
- Getting information from waiver participants about how they like their services
- A formal system to prevent, report, and resolve instances of abuse or neglect.
- Operate the waiver statewide unless the state has permission to only have the waiver in some areas.
- Make sure everyone on the waiver can generally get the same types of services all over the state
- Make sure that people with the same type of needs get the same amount of money to spend on services – called equity of services

Appendix H – Quality Improvement Strategy a summary of the plan for how the waiver will continually determine if it is operating as designed, meeting assurances and requirements, and achieving desired outcome for waiver participants in identifying issues, making corrections and implementing improvements

- updated due to the changes in the performance measures

Appendix I –Financial Accountability explains financial integrity and accountability (rates, billings, claims) through only approved systems

- New performance measures

- ❖ **Key concepts in Appendix I:**

- The state must be financially accountable for ALL funds. This means the state has to know and report:
 - How the money is spent
 - For what services.
- Portability of funding - Medicaid money belongs to the individual not the provider.

Appendix J – Cost Neutrality demonstrates budget neutrality (showing that it is less expensive on average or equal to have participants on the waiver than it is to have them institutionalized); explains:

- Cost neutrality updating

- ❖ **Key Concepts in Appendix J:**

- The state must assure CMS that the waiver is cost neutral – which means that the average cost per person under the waiver can't be more than the average cost per person in an ICF/ID.

Key concepts in terms of waiver services that the waiver says we can't do:

- Can't give cash directly to a waiver participant or parent (but consumer-directed and controlled service are permissible)
- Can't pay for room and board with Medicaid money (except for respite, nutritional supplements, or one meal/day like Meals on Wheels)
- Can't pay or exactly the same stuff under the waiver that is covered by an MA card until you first use up MA card services
- Can't do general home repair with waiver dollars but you can repair housing accessibility modifications
- **Can't pay for services that Vocational Rehabilitation or the public schools are supposed to pay for;**
 - Prevocational and supported employment services may be furnished as expanded habilitation services. However, such services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services and/or supported employment services in a waiver. When a state covers prevocational and/or supported employment services in a waiver, the waiver service definition of each service must specially provide that the services do not include services that are available under the Rehabilitation Act (or, in the case of youth, under the provisions of the IDEA) as well as describe how the state will determine that such services are not available to the participant before authorizing their provision as a waiver service.
 - Waiver funding may not be used to pay for special education and related services that are included in a child's IEP under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). The funding of such services is the responsibility of state and local education agencies. 1903 (c) (3) of the Act provides that FFP is available for services included in an IEP when such services are furnished as basic Medicaid benefits. Waiver services are not considered to be basic Medicaid services and, therefore FFP is not available for IEP special education and related services that may only be funded through an HCBS waiver.
- When the waiver serves individuals under age 21, the service does not duplicate a service that can be provided under the State plan as an expanded EPSDT service.
- Can't cover recreation, guardianship or institutional services other than respite.
- Can't serve people who do not meet the Medicaid eligibility rules
- Must have provider standards, designed by the state and approved by CMS that make sure the people giving support know what they are doing
- Services in the waiver may not duplicate the services that are provided under the State plan but may expand upon the amount, duration and frequency.

- In the case of non-statutory services (such as In Home Support, Parenting Support etc.) the service is necessary to avoid institutionalization and address **functional impairments or other participant needs** that, if left unaddressed, would prevent the person from engaging in everyday community activities.
- Services must describe services to be furnished so that each service is separately defined and in concrete terms the goods and services that will be provided including any conditions that apply to the provision (scope of service)
- Waiver services may be furnished to children in foster care living arrangements but only to the extent that waiver services supplement maintenance and supervision services furnished in such living arrangements and waiver services are necessary to meet the identified needs of children. Waiver funds are not available to pay for maintenance (including room and board) and supervision of children who are under the State's custody, regardless of whether the child is eligible for funding under Title IV-E of the Act.