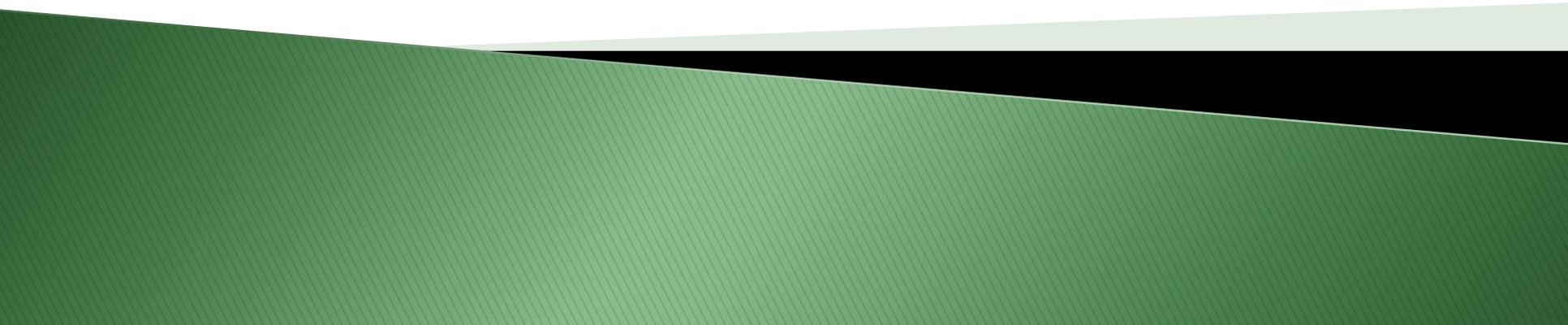


# Waiver Considerations

March 14, 2014

Kristen Edwards



# Waiver Authority

- ▶ CMS requires the Medicaid agency (DSS) to have the ultimate authority
  - Ensure operations are in accordance with:
    - Federal regulation
    - Waiver provisions
- ▶ Medicaid agency retains this authority if delegation of other operational and administrative functions

# Amendments

- ▶ Prospective only
- ▶ For this redesign, four waivers will require amendments (PfH, MOCDD, Comm. Support, Autism)
  - Initial ‘demonstration’ sites
  - Future expansion of ‘demonstration’ sites

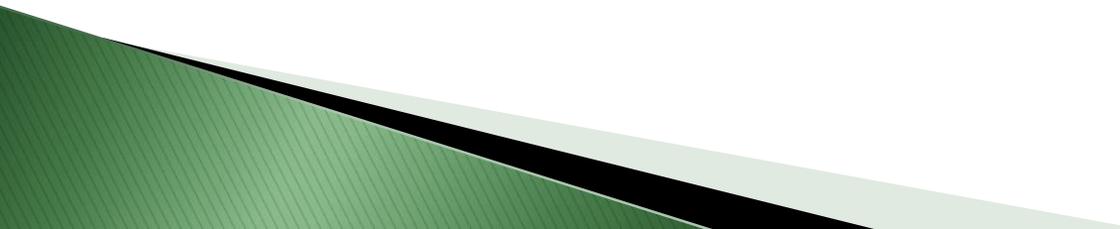
# Timeframes

- ▶ Procedural steps prior to submission to CMS
  - Detailed requirements of delegation and oversight
  - DMH prepare amendments
  - MHD review and amend performance measures and oversight requirements accordingly

# Timelines

- ▶ Upon submission to CMS
  - Date of receipt begins a 90 day clock for approval/questions
  - Informal questions (typically very small magnitude) do not stop the 90 day clock
  - Formal questions (RAI) stop the 90 day clock
  - Once CMS receives responses/changes, a new 90 day clock starts

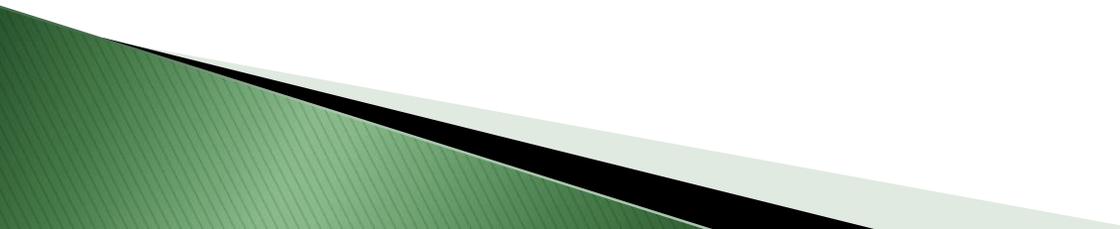
# HCBS Rule

- ▶ Keep in mind that any submission to CMS will trigger the HCBS transition plan requirement
  - ▶ Transition plans will be required for all 10 waivers
    - 5 DMH
    - 5 DHSS
  - ▶ Detailed plan on how and when each waiver will be in compliance with the new HCBS Rule
- 

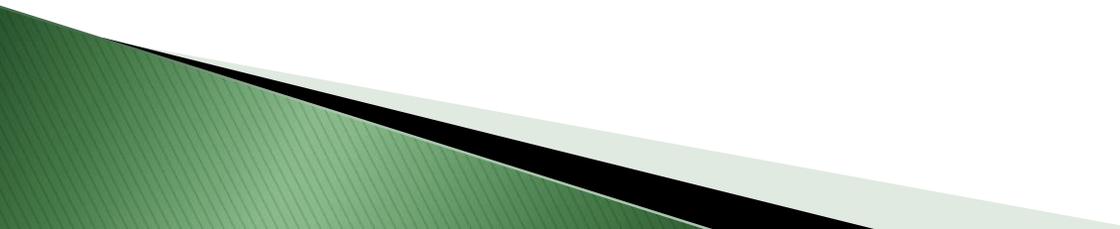
# Delegation

- Appendix A allows for delegation to another state operating agency (DMH), contracted entity, or local non-state entity for some of the following functions:
  - Participant waiver enrollment
  - Waiver enrollment managed against approved limits
  - Waiver expenditures managed against approved levels (Operating Agency and Medicaid Agency)
  - Level of care evaluation
  - Review of participant service plans
  - Prior authorization of waiver services
  - Utilization management
  - Qualified provider enrollment (Medicaid Agency)
  - Execution of Medicaid provider agreements (Operating Agency and Medicaid Agency)
  - Establishment of Statewide Rate Methodology
  - Rules, policies, procedures and information development governing the waiver program (Medicaid Agency must maintain the authority)
  - Quality assurance and quality improvement activities

# Contracting

- ▶ CMS requires contracts when delegating authority
  - ▶ When delegation is to non-governmental entities, contract needs to be a three-party agreement with the Medicaid Agency, Operating Agency and entity.
  - ▶ Must explicitly state the functions being delegated and to whom
- 

# Conflict of Interest (441.730(b))

- ▶ What checks and balances are in place since one entity may be determining eligibility, PON, service authorizations, plan development, and service provider?
  - ▶ New HCBS final rule: “The assessor must be independent; that is, free from conflict of interest with regard to providers, to the individual and related parties, and to budgetary concerns.”
- 

# Provider and Service Choice

- ▶ Providers: “...Medicaid beneficiaries must be allowed to obtain services from any willing and qualified provider of a service.” (42 CFR 431.51)
- ▶ Services: “In short, waiver services must be available on a comparable basis to all waiver participants who have been assessed as needing the services.”
- ▶ How will participants be assured choice of providers and choice of services? How will this be documented in the participant’s record?

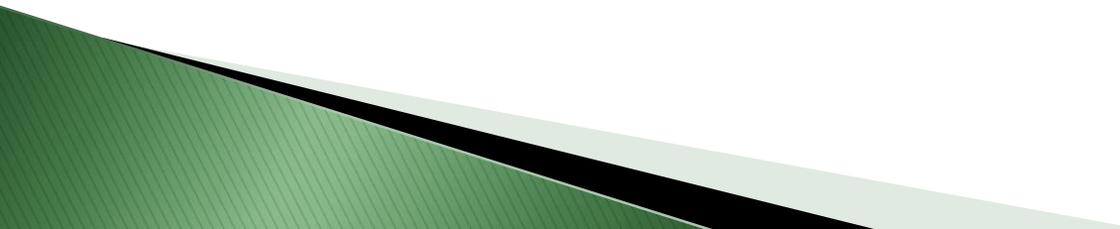
# Statewide Services

- How will there be consistency across the state for areas where delegation to the local level exists and areas where the regional office still performs these functions?
  - “...where the waiver is in effect, the waiver must operate consistently in all the areas served by the waiver.” “...a state must provide for the consistent, uniform administration and operation of the waiver across all geographic areas where the waiver is in operation.”  
Example, consistent decisions made re: authorization waiver services.
  - “Absent a waiver of statewideness, it is expected that the waiver will be administered and operated in a consistent fashion in all parts of the state and, thereby, ensure that waiver services are provided on a comparable basis to the entire target group of waiver participants in compliance with 42 CFR §440.240(b) (comparability of services for groups).”

# Participant Rights

- ▶ Hearings: “A state must provide that individuals have the opportunity to request a Medicaid Fair Hearing when they are not given the choice to receive waiver services, are denied the waiver services or providers of their choice, or their waiver services are denied, suspended, reduced or terminated.”  
(42 CFR 431, Subpart E)

# Oversight

- MHD is the state agency required to have oversight of all functions within the waiver and demonstrate such to CMS.
  - MHDs expectation is that oversight with delegation to the regional office or local agencies be consistent across the two methods.
- 

# New HCBS Rule

- ▶ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>
  - Final Regulation
  - Fact sheets including a summary regarding HCBS settings
  - Webinar Presentation Download

# Questions

- ▶ Any questions or comments?

Contact:

Kristen Edwards or Amy Kessel

MO HealthNet Division

573/751-9290