DIVISION OF
DEVELOPMENTAL
DISABILITIES

Partnership for Hope Waiver

Home and Community-Based waiver

Frequently Asked Questions

January 25, 2019

1. Is there an age range eligible for the Partnership for Hope (PfH)?

   No. There is no age range.

2. What is the Priority of Need for PfH?

   <u>Crisis</u>

   i. **Health and Safety conditions pose a serious risk of immediate harm or death to the individual or others;**
   ii. **Loss of Primary Caregiver support or change in caregiver's status to the extent the caregiver can't meet needs of the individual; or**
   iii. **Abuse, Neglect or Exploitation of the individual.**

   <u>Priority</u>

   iv. **Individual's circumstances or conditions necessitate substantial accommodation that cannot be reasonably provided by the individual's primary caregiver;**
   v. **Person has exhausted both educational and Vocational Rehabilitation (VR) benefits or not eligible for VR benefits and have a need for pre-employment or employment services;**
   vi. **Individual has been receiving supports from local funding for 3 months or more and services are still needed and the service can be covered by the waiver; or**
   vii. **Person living in a non-Medicaid funded Residential Care Facility (RCF) chooses to transition to the community and determined capable of residing in a less restrictive environment with access to the PfH waiver.**

3. Who determines the Priority of Need?

   The participating County Board will prioritize the level of need based on the criteria spelled out in question #2. County Boards that do not provide Targeted Case Management will coordinate the prioritization of enrollment in PfH Waiver with the support coordinator.

4. Are all counties in Missouri participating in PfH?

   No. A map showing the counties currently participating in the PfH program is posted on this link: https://dmh.mo.gov/dd/progs/waiver/docs/pfhmap.pdf

5. Can the remaining counties participate in PfH?

   Yes, however a formal waiver amendment will have to be submitted to the Centers for Medicare and Medicaid Services (CMS). If the County Board makes the decision to provide funding for the waiver, the Division will work with the MO HealthNet Division to submit a waiver amendment to CMS.

6. How long does it take for a waiver amendment to be approved?

   CMS has 90 days to approve a waiver amendment following submission by the state Medicaid authority. If additional information is requested, CMS has another 90 day period in which to approve or deny the amendment from the date the state submits the additional information.

7. How often will the state amend the waiver?

   The Division anticipates submitting waiver amendments up to twice annually depending upon local decisions to join the waiver.

8. How will slots be allocated statewide?

   The process used to allocate slot capacity to participating counties is based on the total number of Medicaid eligible individuals who have been determined eligible for Division of DD services in all of the participating counties, the number of Medicaid eligible individuals who have been determined eligible for Division of DD services in each county, and the number of waiver slots each county requests.

9. Is the PfH waiver slot request form available in electronic format?

   Yes, the form is posted at PfH PON and Request for Waiver Slot Form.

10. If an individual receives the PfH in one county and moves to another participating county who pays for the match?

    The Division will cover the non-federal share of the cost for services after the move until the end of the current state fiscal year (June 30 each year). At the beginning of the next state fiscal year (July 1 each year) the non-federal cost will be shared between the county to where the individual has moved and the Division.

11. Can a person, who is being served in the PfH waiver, continue enrollment in this waiver if they move from a participating county to a non-participating county?

    No. Participants who reside in or move to a county where PfH is not available are informed of the services available where they reside and are served according to the eligibility requirements and prioritization protocols for other waivers. Participants are terminated from the PfH waiver when moving to a county where PfH is not available, and are either enrolled in another waiver, including waivers operated by the Department of Health and Senior Services (DHSS) or are placed on the waiting list depending upon the capacity of the other waivers they may be eligible for.

12. Can a person who resides in a RCF or an Assisted Living Facility (ALF) be enrolled in PfH?

    If a County Board chooses to serve someone who resides in a RCF or ALF, the individual must meet PfH waiver priority criteria and waiver services are only delivered in the community. Ultimately it is the decision of the County Board whether to serve an individual residing in one of these facilities.

13. What is the cap for Environmental Accessibility Adaptations?

    The cap is $7,500 per year. This limit is applied to the waiver year, which begins July 1 and ends June 30 each year. This limit may be exceeded; see Guideline #6 https://dmh.mo.gov/dd/docs/guideline6.pdf

14. What is the cap for Specialized Medical Equipment?

    The cap is $7,500 per year. This limit is applied to the waiver year, which begins July 1 and ends June 30 each year. This limit may be exceeded; see Guideline #6.
    https://dmh.mo.gov/dd/docs/guideline6.pdf

15. Can a person be enrolled in more than one waiver?

    No. If eligible for more than one waiver, they must choose which waiver will best meet their needs.

16. Can a person receive services from an Autism Project and also be enrolled in the waiver?

    Medicaid Waiver enrollees in regions where dual access has been approved by the Parent Advisory Councils (PAC) may ONLY request and access Autism Project services that are not available in the waiver or in Medicaid State Plan services.

17. If a person is enrolled in the PfH waiver, may they remain on the wait list for other waivers? (Comprehensive and Community Support)

    Yes. A person may only be disenrolled from PfH and enrolled in a different waiver if they meet the eligibility and prioritization criteria of the other waiver as detailed in 9 CSR 45-2.015-2.017.

18. Can the waiver supplant services already covered by a program administered by another state agency?

    No.

19. Can a person remain in the waiver if they do not receive services on an on-going basis?

    No. If the individual has a one-time service need, they should be dis-enrolled once the service has been provided. For intermittent service needs, such as Temporary Residential Service, services should be used at least every 90 days.

20. If a person is in the PfH Waiver can they still receive POS or Choices funding?

    Individuals currently receiving services funded through the Choices for Families program are not excluded from participation in the PfH. If a service historically funded through Choices could be funded through the PfH, then it is expected that the PfH waiver would become the funding source for that service. If PfH is unable to fund that service, then funding through Choices could continue. No new entry into the Choices for Families program is allowed.

21. Can a county board supplement PfH waiver services with other services funded 100% by the county?

    Yes.

22. Can a county board choose to cover only certain waiver services, but not all?

    No. Participating county boards must cover the entire range of services covered under the waiver. Federal law requires the state to meet all of the needs identified in any waiver participant's support plan. Needs may be met with a combination of natural supports, state plan services, and waiver services.

23. If a person voluntarily withdraws from the waiver, do they have appeal rights?

    Yes. A formal written notice is required, the same as with any other service reduction.

24. Do support plans for persons participating in the PfH waiver have to go through the Regional Office Utilization Review process?

    No. Support plans for persons in the PfH Waiver go immediately to the Regional Director for approval.

25. How does the exceptions process work?

    If an individual has needs in excess of the cost limit of $12,362 to ensure health and welfare of the individual an exception may be granted for additional services above the individual cost cap.

    Process

    i. **SC will revise the support plan**
    ii. **County Board Director will request the exception**

iii. **Final approval of the exception is by the Division Director or designee.**

26. Under what circumstances an exception to $12,362 annual spending cap may be granted?

    A one-time expense of up to $10,000 may be granted annually to address a crisis or transition period. An exception may be granted on an on-going basis for up to $3,000 annually (a total of $15,000 in waiver services annually).

27. If exceptions are granted where will the funding come from?

    The County Board will pay 50% of the match and the Division will pay 50% of the match for the exceptions increase.

28. If a service needs to be increased from the original request, but is still under the $12,362 cap, does this need to go thru the Regional Office Utilization Review?

    Regional Office Utilization Review does not approve original support plans or increases in support plans that are still within the cost caps. When support plans will exceed the cost cap, the Division Director or designee, may approve exceptions to the caps in collaboration with the County Board Director.

29. Do state plan services count toward the $12,362 annual cost cap?

    No. Only waiver services are counted toward the cost cap.

30. Will the state consider increasing the PfH annual spending cap**?**

    The cost limit will be adjusted annually by the Consumer Price Index (CPI).

31. Can the 60 day limit on temporary residential be exceeded on a case by case basis?

    Temporary Residential service is limited to no more than 60 days annually, unless a written exception is granted from the regional office director. This limit may be exceeded on an individual basis when necessary to protect the health and welfare of a waiver participant subject to the approval of both the county board and regional directors. The 60 days may be consecutive, unless the service is provided in an ICF/ID or State Habilitation Center. Temporary Residential Service provided in an ICF/ID or State Habilitation Center cannot exceed 30 days.

Dental Service Frequently Asked Questions

32. What types of dental services are covered under the PfH Waiver?

Preventive dental treatment-topical fluoride applications. Therapeutic dental treatment-pulp therapy for permanent teeth; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable.

33. Do all PfH dental services have to be prior authorized?

Any dental services through the PfH Waiver must be prior authorized by the participating county and the regional office before the service can be provided. Typically, the local office will authorize an examination, and will then issue another authorization based on the dental treatment plan developed by the dentist.

Contact information for the regional offices is on this website:
https://dmh.mo.gov/dd/facilities/

34. What are the rates for the PfH waiver dental services?

The dentist or dental clinic may be reimbursed at their usual and customary charge for procedures. The PfH Waiver is not limited by the MO HealthNet fee schedule for dental services. For dental services, the authorized amount cannot exceed the maximum allowed rate set by the State for the service.

35. Do the PfH waiver dental services cover any hospital operating room charges?

The PfH dental service may only cover the charges submitted by the authorized dentist. Charges for anesthesiology, operating room or other costs may be reimbursed by MO HealthNet or Medicare, subject to the benefits and limitations of those programs. If ancillary services are necessary for the dental treatment plan and are not covered by MO HealthNet or Medicare, please contact the regional office serving the county where the patient resides.

36. Are there cost limits to PfH dental services?

The PfH has an annual per-participant cost cap of $12,362. This limit applies to all waiver services provided to the individual, including dental. The limit does not include other medical care such as physician, pharmacy, inpatient hospital, health home, or other services covered by the MO HealthNet state plan. The waiver has an exceptions process that allows an additional $3,000 to $10,000 to be authorized annually on a case by case basis.

37. Are there any limitations to the PfH dental benefit?

Dental services for individuals under the age of 21 are not covered. Dental services for individuals under the age of 21 may be accessed under the State plan as a Healthy Children and Youth (HCY/EPSDT) benefit. This PFH waiver service is only provided to individuals age 21

and over. All medically necessary "Dental" services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Dental services for adults exclude the following:
Any service that may be covered under the State plan Medicaid program.
The following dental services may require prior authorization: treatment for trauma of the mouth, jaw, teeth, or other contiguous sites as a result of an injury; and treatment of a disease/medical condition without which the health of the individual would be adversely affected and would result in a higher level of care. It also includes preventive services, restorative services, periodontal treatment, oral surgery, extractions, radiographs, pain evaluation and management, infection control, and general anesthesia.

38. If the dentist's office is not located in a county participating in PfH, can the dentist contract to provide waiver dental services?

    Yes. Dentists may accept referrals to provide dental treatment to participants of the PfH waiver from any county in the PfH waiver service region. Waiver participants have a free choice from among all waiver providers under contract with a Regional Office or a County Board. Transportation is also covered through the waiver if the participant has no other means to access a waiver service.