



Partnership for Hope Waiver
County-based Home and Community-based waiver

Frequently Asked Questions

May 31, 2013

1. Is there an age range eligible for the Partnership for Hope?
 - a. **No. There is no age range for persons available for Partnership for Hope waiver.**

2. What is the priority of need for Partnership for Hope?
 - a. **Crisis**
 - 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.**
 - b. **Priority**
 - i. **Individual's circumstances or conditions necessitate substantial accommodation that cannot be reasonably provided by the individual's primary caregiver;**
 - ii. **Person has exhausted both educational and VR benefits or not eligible for VR benefits and have a need for pre-employment or employment services;**
 - iii. **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. Refinancing; or**
 - iv. **Person living in a non-Medicaid funded 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?
 - a. **The participating County Board will prioritize the level of need based on the criteria spelled out in the question 2. County Boards that do not provide Targeted Case Management will coordinate the prioritization of enrollment in Partnership for Hope Waiver with the support coordinator.**
4. Are all counties in Missouri participating in Partnership for Hope?
 - a. **No. A map showing the counties currently participating in the Partnership for Hope program is posted on this link: <http://dmh.mo.gov/docs/dd/pfhmap.pdf>**
5. Can other counties participate in Partnership for Hope?
 - a. **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?
 - a. **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?
 - a. **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?
 - a. **As of state fiscal year 2013, the waiver has a capacity of 2870 participants. Slots are managed at DD Central Office assigned immediately upon request. When enrollment in the waiver is within 100 participants of full capacity, an assessment of need to expand will be conducted and an amendment request may be submitted to CMS with the approval of the Governor's office.**
9. Is the Partnership for Hope waiver slot request form available in electronic format?
 - a. **Yes, the form is posted at <http://dmh.mo.gov/dd/progs/waiver/partnership.htm>**
10. If an individual receives the Partnership for Hope in one county and moves to another participating county who pays for the match?
 - a. **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 Partnership for Hope waiver, continue enrollment in this waiver if they move from a participating county to a non-participating county?
 - a. **No. The state has federal authority to only offer this program in counties who have agreed to participate. If the person moves to a non-participating county, they must be disenrolled from the Partnership for Hope waiver. The participant must be given a written notice terminating their waiver participation and offering the opportunity to appeal. They will be placed on the waiting list for participating in another waiver based on their prioritization of need score.**

12. Can a person who resides in a residential care facility (RCF) or an assisted living facility (ALF) be enrolled in Partnership for Hope?
 - a. **Page 3 of the waiver states “the waiver will offer preventive services to stabilize individuals primarily living with family members who provide significant support, but are not able to meet all of the individual’s needs.” While RCFs and ALFs are technically considered home and community-based living settings, they are also congregate settings and receive state and federal funds to comprehensively meet the basic support needs of the individual. If a County Board chooses to serve someone who resides in a RCF or ALF, the individual must meet Partnership for Hope waiver priority criteria. Waiver personal assistance should not be provided to anyone residing in a RCF or ALF as these facilities are eligible to enroll as Medicaid providers and bill state plan personal services. 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?
 - a. **The cap is \$7,500 per year. This limit is applied to the waiver year, which begins October 1 and ends September 30 each year. This limit may be exceeded; see Guideline #6 <http://dmh.mo.gov/docs/dd/Guideline6.pdf>**

14. What is the cap for Specialized Medical Equipment?
 - a. **The cap is \$7,500 per year. This limit is applied to the waiver year, which begins October 1 and ends September 30 each year. This limit may be exceeded; see Guideline #6. <http://dmh.mo.gov/docs/dd/Guideline6.pdf>**

15. Can a person be enrolled in more than one waiver?
 - a. **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?
- a. **No. They must choose which program best meets their needs but cannot receive services under both.**
17. If a person is enrolled in the Partnership for Hope waiver, may they remain on the wait list for other waivers? (Autism, Comprehensive, 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 personal assistant be used to provide in-home respite?
- a. **Yes.**
19. Can the waiver supplant services already covered by a program administered by another state agency?
- a. **No.**
20. Can a person remain in the waiver if they do not receive services on an on-going basis?
- a. **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.**
21. If a person is in the Partnership for Hope Waiver can they still receive POS or Choices funding?
- a. **No, as with Autism Project services, the person must choose which program best meets their needs but cannot receive services under both waiver and state-funded programs.**
22. Can a county board supplement Partnership for Hope waiver services with other services funded 100% by the county?
- a. **Yes.**
23. Can a county board choose to cover only certain waiver services, but not all?
- a. **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.**
24. If a person voluntarily withdraws from the waiver, do they have appeal rights?
- a. **Yes. A formal written notice is required, the same as with any other service reduction.**
25. Do support plans for persons participating in the Partnership for Hope waiver have to go through the Regional Office Utilization Review process?

- a. **No. Support plans for persons in the Partnership for Hope Waiver go immediately to the Regional Director for approval.**

26. How does the exceptions process work?

- a. **If an individual has needs in excess of the cost limit of \$12,000, 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.**

27. Under what circumstances an exception to \$12,000 annual spending cap may be granted?

- a. **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).**

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

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

29. If a service needs to be increased from the original request, but is still under the \$12,000 cap, does this need to go thru the Regional Office Utilization Review?

- a. **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.**

30. Do state plan services count toward the \$12,000 annual cost cap?

- a. **No. Only waiver services are counted toward the cost cap.**

31. Will the state consider increasing the Partnership for Hope annual spending cap?

- a. **The adequacy of the spending cap will be re-evaluated as the state gains experience with this new waiver. If it is determined that \$12,000 and the current exceptional categories and limits are insufficient, a waiver amendment may be submitted to CMS, with approval from the Governor's office.**

32. How do OHCDs providers set up contracts and establish prices for the service being provided such as dental services?

- a. **The division has conducted outreach to federally qualified health center dental clinics and to independent dentists, and has contracts with several dental providers. County Boards may use these dentists and bill through the Regional Office OHCDs.**
 - b. **County boards wishing to use their own OHCDs may also contract directly with dentists. Contact all local dentists to find out who is willing to serve individuals with disabilities and what their fees are. You may have to contact other OHCDs counties to get examples of written agreements.**
 - c. **Contractor needs to have an agreement with signatures with the subcontractor to include the components of the POS contract Section 3.11.C.**
 - d. **Services are approved by the planning team and an authorization is entered in CIMOR with the designated County as the provider. The amount at this time will have to be estimated unless you have a quote from a dentist. The authorization cannot exceed the \$12,000 annual cap. Dentists are to charge their reasonable and customary fees unless there is additional expense related to the disability. The code billed to Medicaid is a broad, fairly generic code for the total amount so there's no validation of individual procedure limits. We're asking counties to maintain the detail invoice so there is a record of the actual services performed.**
 - e. **The OHCDs will pay the dentist for services rendered and keep documentation of the services provided, dates of services, amounts billed, and amounts reimbursed.**
 - f. **OHCDs will bill through CIMOR and be reimbursed through MO HealthNet.**
32. Do Regional Offices need a certain type of protocol to add "dental" on the wait list? Historically we haven't added dental to the wait list, but now with the PfH waiver it is a covered service. So we were unsure on how to indentify that as a needed service other than stating it in the plan.
- a. **Regional Offices and County Boards may contract with any licensed dentist who is willing to serve people with DD. You should not pay more than the dentist's usual and customary fee for any procedure – if you are able to negotiate a reduced fee that is okay. The dentist should be reassured they will be reimbursed by the Regional Office or County Board directly, and will not bill MO HealthNet. The Regional Office or County Board bills under their OHDCS number. There are available slots for the PfH waiver currently, the only DD waiver with the dental service. If the individual meets ICF/MR LOC and other requirements for waiver eligibility, and dental needs are identified as part of overall needs and services through HCB services, the individual should be able to receive the dental service without being placed on a wait list. In the future, should there be a period when all PfH slots are encumbered, there may be a wait list factor within the PfH slots approval process (this process unique only to the PfH waiver and would need to meet crisis and/or priority level), as slots requested and approved are not subject to the Utilization Review process like the other DD waivers.**

35. Can the 60 day limit on temporary residential be exceeded on a case by case basis?
a. **Not at this time; however the pending re-application of the Partnership for Hope waiver, currently pending review with CMS; allows this limit to be exceeded on a case-by-case basis subject to approval by both the directors of the County Board and the Regional Office. This will become effective October 1, 2013, contingent upon CMS approval.**

36. When will day service be changed to Independent Living Skills Development as in the other waivers?

a. The waiver reapplication, pending review by CMS, replaces day service with Independent Living Skills Development.

A copy of the current waiver can be viewed and a printed from the DD website:

<http://dmh.mo.gov/dd/progs/waiver/partnership.htm>

CMS posts all states' waivers on their website but may not always have the most current approved waiver or amendment posted:

<https://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp>