1915(c) Traditional IID/DD HCBS Waiver Informational Meeting

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August 14, 2023

Agenda

- What is a waiver
- Waiver appendices
  - CMS Quality Assurances
  - Proposed changes for 2024 renewal
- Feedback

Disclaimer:

- The purpose of this meeting is to provide education to stakeholders about the Traditional IID/DD HCBS waiver, renewal process, and items being considered for the 4/1/24 waiver. All items being considered are in draft form and subject to CMS approval.

- We will not be able to answer specific questions today, however all stakeholders will have an opportunity to provide public comment prior to the waiver being submitted to CMS.

Definitions

- CMS-Centers for Medicare and Medicaid Services
- HCBS- Home and Community Based Services
- IID/DD- Individuals with Intellectual Disabilities and Developmental Disabilities
- FMAP- Federal medical assistance percentage
- ICF/IID- Intermediate Care Facility for Individuals with Intellectual Disabilities
- State Fiscal Year- July 1 to June 30
- Traditional IID/DD HCBS Waiver Year- April 1 to March 31

1915(c) Traditional IID/DD HCBS Waiver

What is a waiver?

- Section 1915 c of the Social Security Act was changed to allow states to ask for waivers.
- A waiver means that the regular rules are “waived”— that is regular rules are not applied.
- 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.
  - ***This is why 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.

1915(c) Traditional IID/DD HCBS Waiver

- **Benefits of a Waiver:**
  - People can choose services in the community where they can live with family and friends.
  - The state 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” (FMAP) what the state pays.
  - The waiver must operate based on the spending/budget that is designated by the Legislature.

1915(c) Traditional IID/DD HCBS Waiver

Waiver Renewal/Approval Process

- Initial waivers are approved for up to 3 years, after that renewals are approved for up to 5 years.
  - ND IID/DD Waiver year is April 1- March 31
- States are required to have a 30-day public comment period. This must be completed before the waiver is submitted to CMS for approval.
- CMS has 90 days to review and approve the renewal. During this time period CMS and the State will engage in a question and answer period. If significant concerns arise and they unable to be resolved, CMS may stop the clock until a resolution has been agreed to. This may delay the effective date of the proposed changes.

Appendix A – Waiver Administration & Operation

Explains who is operating the waiver, who has oversight of the waiver, any contracted entities (i.e. fiscal agent -Veridian), and assessment methods of the entities.

- The State Medicaid agency must retain oversight over all aspects of the Waiver.
- The DD Section has day to day responsibility for operation.

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Appendix A – Waiver Administration & Operation

CMS Quality Assurance

- The 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 (if appropriate) and contracted entities.

State's Performance Measure

- The State reports on services being paid accurately for self directed services.

Appendix A – Waiver Administration & Operation

No significant changes proposed.

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 level of care (LOC).

- Slots – these include a “reserved capacity” which is 170 for Infant Development, 15 for emergency, & 5 for extended employment services.
  - Year 1 5830
  - Year 2 6380
  - Year 3 6530
  - Year 4 6680
  - Year 5 6830 *current waiver year 2023-2024

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Appendix B - Participant Access & Eligibility

Who can receive a HCBS 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 aged 65 and older) or disabled; or both;
  - Persons with intellectual disability or a developmental disability or both;
  - Persons with mental illnesses.

Appendix B - Participant Access & Eligibility

To receive IID/DD waiver services, individuals must be in the ID or DD target group AND also meet the level of care (ICF/IID).

DD Section Eligibility Criteria Age 3 & Older

1) Intellectual disability with a developmental disability;
2) Intellectual disability with no developmental disability but able to benefit from DD services; or
3) Related condition with a developmental disability and able to benefit from DD service

DD Section Eligibility Criteria Birth through Age 2

1) 25% delay in 2 areas;
2) 50% delay in 1 area;
3) High risk of becoming developmentally delayed; or
4) Informed clinical opinion of becoming developmentally delayed

Appendix B - Participant Access & Eligibility

ICF/IID level of care

- Per federal regulation this level of care is for people with an ID or related condition defined by 42 CFR 435.1009
- Participants linked to the ICF/IID level of care must meet the related condition definition when not diagnosed as having an ID
- Related condition are those who have a disability closely related to people with ID and who require similar services and benefit from those services

Note: DD and related conditions may overlap, however, they are not equivalent. DD is a broad term that includes any mental, cognitive, or physical conditions that may have no components closely related to ID.

Appendix B - Participant Access & Eligibility

CMS Quality Assurance

The State demonstrates the processes are implemented as described in the waiver for evaluating a person's ICF/IID level of care.

State's Performance Measures

- The State reports that participants meet the initial level of care (ICF/IID) prior to services starting.

- The State reports the initial level of care (ICF/IID) was accurately completed.

Appendix B - Participant Access & Eligibility

Proposed Changes

- Increase in 150 waiver slots per year
  - Year 1 (6980)
  - Year 2 (7130)
  - Year 3 (7280)
  - Year 4 (7430)
  - Year 5 (7580)
- Emergency slots: remove the requirement they must be moving from a State institution (Life Skills and Transition Center) and expanded it to any institutional setting.(State Hospital, Skilled Nursing Facilities, ICF/IID)

Appendix C - Participant Services

Summary of all the services, any service limitations, and provider requirements

Current services:

- **Day Habilitation**
- **Homemaker**
- **Independent Habilitation**
- **Individual Employment Support**
- **Prevocational Services**
- **Residential Habilitation**
- **Extended Home Health Care**
- **Adult Foster Care**
- **Community Transition Services**
- **Behavioral Consultation**
- **Environmental Modifications**
- **Equipment and Supplies**
- **Family Care Option**
- **In-Home Supports**
- **Infant Development**
- **Parenting Support**
- **Small Group Employment Support**

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Appendix C - Participant Services

CMS Quality Assurance

The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

State's Performance Measures

- The State reports providers meet licensure requirements initially and continually.
- The State reports self directed services have met ND State requirements.
- The State reports full-time DD licensed provider staff have successfully completed State required module training.
- The State reports staff who administer medications through a licensed DD provider have completed the medication training requirements

Appendix C - Participant Services

Proposed Changes

- Day Habilitation
  - Added clarifying language that retirement activities are allowable under this service.
- Day services (Day Habilitation, Individual Employment Support, Small Group Employment Support, and Prevocational Services)
  - Added clarifying language in the limit section that an individual's total service hours authorized may not exceed 40 cumulative hours per week.
- Homemaker
  - Limits adjusted- shopping is allowed as only task

Appendix C - Participant Services

Proposed Changes

- Individual Employment Support and Small Group Employment Support
  - Added clarifying language that transportation from a participant's residence to their workplace may be included in the authorized service hours if personal, public, or generic transportation is not available.
- Residential Habilitation
  - Added clarifying language that the residental habilitation provider is responsible for coordinating or providing transportation needs. Participant may be responsible for the costs.
- Adult Foster Care
  - Added clarifying language that Respite may be a component of this service.

Appendix C - Participant Services

Proposed Changes

- Environmental Modifications
  - Added clarifying language that if a vehicle is purchased with adaptations (i.e. lift, ramp), reimbursement for those adaptations may be approved if they are itemized on the invoice.
  - Increase limit from $20,000 to $40,000 per waiver period (5 years).
- Equipment and Supplies
  - Provided a definition for the term generic item(s) to align with current practices.

Appendix C - Participant Services

Proposed Changes

- In-Home Supports
  - Added that a participant can be authorized for both provider managed and self-directed but cannot be furnished or billed at the same time of day. The total authorized amounts are not transferable between the different service delivery methods (i.e. self-directed, provider managed).
- Parenting Supports
  - Removed due to lack of utilization. Supports and goals may be encompassed within other waiver services or community services.

Appendix C - Participant Services

Proposed Changes

- Respite
  - New stand-alone service and will no longer be a component of In-home support.
  - Respite may be utilized in addition to In home supports.
  - Purpose is to give temporary relief to the primary caregiver from daily stress, care demands and to prevent or delay unwanted out of home placement. Temporary means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
  - Limited to a total of 600 hours per State Fiscal Year per participant

Appendix C - Participant Services

Proposed Changes

- Residential Habilitation, Independent Habilitation, In-Home Supports and Respite
  - A participant receiving services listed above may continue to receive those supports while admitted to an acute care hospital setting to meet the needs of the participant that are not met through the provision of hospital services.
  - This is not intended to substitute services that the hospital is obligated to provide under Federal or State law.

Appendix D - Participant Centered Planning & Services

Explains the participant development of the service plan, implementation, and monitoring of the plan

- Waiver requirement that everyone has an individual plan of care developed by qualified individuals.
- Individual 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.

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Appendix D - Participant Centered Planning & Services

CMS Quality Assurance

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

State's Performance Measures

- The State reports that plans address health and safety needs identified through the assessment process.
- The State reports that plans address personal goals identified through the assessment process.
- The State reports that plans are updated at least annually or when a participant's needs change.

Appendix D - Participant Centered Planning & Services

State's Performance Measures continued

- The State reports that participants have received services in accordance with their plans.
- The State reports that services delivered as specified, including the type, scope, amount, duration, and frequency.
- The State reports participants have chosen between waiver services and providers.

Appendix D - Participant Centered Planning & Services

No significant changes proposed.

Appendix E - Participant Direction of Services

Explains how participants can self-direct their services, what services are self-directed, and whether or not a third party is involved. Services that can be self-directed include:

- In-home Supports
- Behavioral Consultation
- Environmental Modifications
- Equipment and Supplies

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Appendix E - Participant Direction of Services

Proposed Changes

- Respite would be able to be self-directed

Appendix F - Participants Rights

Explains a participant's opportunity for a fair hearing, dispute resolutions, grievances, and complaints

- Participants can choose any provider that is qualified under state law.
- Participants have the right to appeal when a service is denied, suspended, terminated ,or reduced.

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Appendix F - Participants Rights

Proposed Changes

- Language updated to align with grievance policy

Appendix G - Participants Safeguards

Explains Abuse, Neglect, Exploitation (A, N, E) processes, management of medication administration, and restraint/restrictions

- How reported
- When to report
- What to report
- State oversight and monitoring
- Interventions and safeguards

Appendix G - Participants Safeguards

CMS Quality Assurance

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

State's Performance Measures

- The State reports that participants have been informed of their rights.
- The State reports unexplained deaths that were investigated.
- The State reports where abuse, neglect, or exploitation are substantiated, and follow-up is completed.

Appendix G - Participants Safeguards

State's Performance Measures continued

- The State reports serious events that were reported within required time frames.
- The State reports risk management steps were implemented for ANE/Serious events that required investigation.
- The State reports that incidents are reported per DD Policy.
- The State reports that follow up was completed on restraints that were substantiated through investigation.
- The State reports that follow up was completed on restrictive interventions that were substantiated through investigation.
- The State reports substantiated choking incidents for waiver participants.

Appendix G - Participants Safeguards

Proposed Changes

- Changing performance measure from substantiated choking incidents to medication errors substantiated through investigation.

Appendix H - Quality Improvement Strategy

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

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Appendix H - Quality Improvement Strategy

No significant changes proposed.

Appendix I - Financial Accountability

Explains financial integrity and accountability (rates, billings, claims) through only approved systems

- The State must be financially accountable for ALL funds. The State reports:
  - How the money is spent,
  - For what people and;
  - What services.

- Portability of funding - Medicaid money belongs to the individual, not the provider.

Appendix I - Financial Accountability

CMS Quality Assurance
The State must demonstrate that it has designed and implemented adequate system for insuring financial accountability of the waiver program.

State's Performance Measures

- The State reports that claims paid within individual's person-centered plan authorization.
- The State reports that provider payment rates that are consistent with the rate methodology in the approved waiver.

Appendix J - Cost Neutrality

Demonstrates budget neutrality

- 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/IID.

Tentative Timelines

- Beginning of public comment September 15, 2023
- Submit to CMS November 1, 2023
- Expected Start date of new waiver period April 1, 2024

Contact infomration:
Heidi Zander – DD Waiver Administrator
Hzander@nd.gov