January 2020

Children, Families, Health, and Human Services Interim Committee
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HJR 50: SENIOR/LONG-TERM CARE SUMMARY OF CITATIONS

BACKGROUND

The Children, Families, Health, and Human Services Interim Committee asked for an explanation of the federal and state laws and regulations related to recent policy changes for the Big Sky Waiver. At the committee's November 2019 meeting, the Department of Public Health and Human Services (DPHHS) provided a list of policy changes dating back to January 2018. The list cited the various state and federal provisions that authorized the changes. DPHHS will discuss the policy changes in more depth at the January 2020 meeting.

This briefing paper summarizes the citations to state and federal authority provided in November.

FEDERAL PROVISIONS

In addition to the section of the Social Security Act that authorizes waivers for Medicaid funding of home and community-based (HCBS) services, DPHHS cited the federal regulations related to HCBS waivers in general and the regulations specific to HCBS waivers for individuals age 65 or older. The requirements are found in 42 CFR 441.300-310 (Subpart G) and 42 CFR 441.350-365 (Subpart H).

SUBPART G: HCBS WAIVER REQUIREMENTS

This subpart of 42 CFR 441 sets out the general requirements for any type of home and community-based services waiver for the Medicaid program. DPHHS cited the following regulations:

- **42 CFR 441.300: Basis and purpose**: Establishes that states may waive statutory requirements to offer home and community-based services that are specified in federal regulation and that allow a person to avoid institutionalization.
- **42 CFR 444.301: Contents of request for a waiver**: Spells out the elements that any HCBS waiver application must contain; establishes requirements for home and community-based settings; and prohibits services provided in institutional setting; requires a person-centered planning process and service plan; and requires review of service plans at least annually.

- **42 CFR 444.302: State assurances.** Requires states to satisfactorily ensure that: safeguards are in place to protect the health and welfare of program participants; financial accountability exists for waiver expenditures; program participants are evaluated to determine the level of care needed; average per capita and total expenditures will remain within statutory caps; and habilitation services provided under the waiver are not otherwise available to participants through other programs.
- **42 CFR 441.303: Supporting documentation required.** Requires states to provide the Centers for Medicare and Medicaid Services (CMS) with enough information to support the assurance it has made under 42 CFR 441.302.
- **42 CFR 441.304: Duration, extension, and amendment of a waiver.** Allows for an initial 3-year waiver period that may subsequently be extended for additional 5-year periods; requires that substantive changes to the type, scope, amount, or duration of services be submitted to CMS for approval and be subject to a public comment period.
- **42 CFR 441.305: Replacement of beneficiaries in approved waiver programs.** Allows a state to replace program participants who leave the waiver program for any reason.
- **42. CFR 441.306: Cooperative arrangements with the Maternal and Child Health program.** Allows DPHHS to enter into cooperative arrangements with the program that assists children with special health care needs through the federal Maternal and Child Health Program.
- **42 CFR 441.307: Notification of a waiver termination.** Requires the state to notify CMS 30 days before terminating a waiver early and to notify waiver participants of the termination 30 days before services are ended.
- **42 CFR 441.308: Hearings procedures for waiver terminations.** Establishes the process to be used when a state requests a hearing on federal termination of a waiver program.
- **42 CFR 441.310: Limits on Federal financial participation (FFP).** Establishes that federal funds are not available under certain circumstances, including for: services and facilities that don't meet health and welfare standards; the costs of room and board in most instances; and prevocational, educational, or supported employment services in certain instances.

SUBPART H: HCBS WAIVERS FOR INDIVIDUALS AGE 65 OR OLDER

Subpart H of 42 CFR 441 is specific to HCBS waivers for elderly individuals and contains many sections that essentially duplicate Subpart G requirements for waiver contents, state assurances and documentation, waiver duration and terminations, hearing procedures, and limits on federal matching funds. The regulations also include the provisions below.

- **42 CFR 441.350: Basis and purpose.** Allows states to offer waiver services to people age 65 or older in exchange for accepting an aggregate limit on the amount of expenditures for which they can claim federal matching funds.
- **42 CFR 441.354: Aggregate projected expenditure limit (APEL).** Requires that the amount of Medicaid funding that a state spends for a nursing facility, HCBS waiver services, home health services, personal care services, private duty nursing services, and other services furnished under an HCBS waiver to people 65 years of age or older as an alternative to nursing home or institutional care may not exceed an amount known as the Aggregate Projected Expenditure Limit, or APEL; provides a formula for calculating the APEL.
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- **42 CFR 441.365: Periodic evaluation, assessment, and review.** Requires that the care and services provided to waiver participants be evaluated at least annually by a review team that includes at least one doctor or registered nurse and one other person with health and social services credentials to determine if services are adequate and should be continued; members of review teams may not have a financial interest in or be employed by any waiver provider.

OTHER FEDERAL LAWS AND REGULATIONS AT PLAY

DPHHS also cited the following federal laws and regulations that govern its policies for the Big Sky Waiver:

- **42 USC 1396r-5:** Establishes how the income and resources of a married couple will be treated in calculating the income available to a spouse who is institutionalized.
- **42 CFR 431.210. Content of notice.** Spells out the information a notice involving denial of or a change in benefits must contain, including information about the right to a fair hearing.
- **42 CFR 431.211. Advance notice.** Requires that DPHHS sends a notice of its planned action on denial or change of benefits at least 10 days before the action is taken.
- **42 CFR 435.831. Income eligibility.** Establishes the method by which income eligibility for medically needy individuals must be calculated.
- **42 CFR 440.60. Medical or other remedial care provided by licensed practitioners.** Defines the medical and remedial care that may be provided; and specifies the chiropractic services that may be covered.

BIG SKY WAIVER PROVISIONS

DPHHS cited several portions of the Big Sky Waiver application, as described below.

- **Application Introduction: Page 7.** Provides that the approved waiver application will authorize the state to provide home and community-based services to the groups specified in the waiver.
- **Application Request Information (2 of 3).** Requests a waiver to provide home and community-based services to individuals who would otherwise require nursing facility services as defined in federal regulations.
- **Application Request Section 5.** Provides assurances that the state will comply with federal requirements, including: taking steps to protect the health and welfare of waiver participants; providing accountability for waiver funding and ensuring the state does not exceed the cap on total expenditures; regularly evaluating the service needs for waiver participants; and ensuring that prevocational, educational, or supported employment services provided under the waiver are not otherwise available to an individual through other means or programs.
- **Appendix A: Waiver Administration and Operation**. Describes how DPHHS will administer the waiver, including the functions that will be handled by third-party contractors, the reporting requirements contractors must meet, and procedures for resolving any deficiencies in the contractors' outcomes.
- **Appendix B-B3: Number of Individuals Served.** Sets the number of unduplicated waiver participants at 2,580 in each year of the waiver; allows the state to reserve up to 20 slots a year who are transitioning from institutional settings to the waiver through the Money Follows the Person demonstration program; and specifies the criteria to be used for moving people from the waiting list into the waiver.
- **Appendix B-B4: Eligibility Groups Served in the Waiver.** Establishes the Medicaid eligibility groups to be served by the waiver.

- **Appendix B-B6: Evaluation/Re-evaluation of Level of Care.** Specifies the level of care criteria to be used in determining if a person needs waiver services; requires re-evaluation of the level of care at least annually; and requires that a person needs at least one waiver service at least once a month to qualify for the waiver.
- **Appendix C-C1/C3: Service Specification.** Lists each of the services covered under the waiver.
- **Appendix D: Participant-Centered Planning and Service Delivery.** Establishes requirements for developing a participant's service plan and methods for ensuring that the plan is developed properly and services are delivered as planned.
- **Appendix D-D1: Service Plan Development.** Provides that case managers will develop service plans; specifies the minimum components of a service plan; requires that case management teams approve the service plan; and requires review of the service plan at least every 6 months.
- **Appendix D: Pages 140-149.** Establishes facility standards and scope of services; authorizes family members and legal guardians to provide waivers services; and authorizes the use of self-directed care.
- **Appendix E: Participant Direction of Services.** Allows waiver participants to self-direct their waiver services by making employment, reimbursement, and purchasing decisions related to the services they receive.
- **Appendix F-F1: Opportunity to Request a Fair Hearing.** Provides that participants may request a fair hearing for decisions related to denial, suspension, reduction, or termination of eligibility, services, or choice of service providers.

STATE ADMINISTRATIVE RULES

DPHHS cited the following administrative rules in Title 37, chapter 40, subchapter 14, as guiding its policy decisions. The subchapter contains rules for home and community-based services for elderly and physically disabled persons.

- **37.40.1401: Authority and scope of program.** Cites the federal statutory and regulatory authority for establishing the HCBS waiver and notes DPHHS can decide the number of people and the amount, scope, and duration of services the program will cover.
- **37.40.1406: Services.** Specifies the allowable waiver services and the reasons services may be denied.
- **37.40.1408: Enrollment.** Establishes the eligibility criteria for waiver services and the factors for deciding whether an individual should be enrolled in the waiver.
- **37.40.1415: Reimbursement.** Specifies the services that are reimbursable under the waiver and allows DPHHS to set the reimbursement rate.
- **37.40.1420: Service plans.** Establishes requirements for the service plan that outlines the supports and interventions that a person needs.
- **37.40.1421: Cost of service plan**. Allows DPHHS to limit the cost of service plans in order to remain within funds appropriated for the program; allows adjustments to the cost of services provided to a person if the person's needs change.
- **37.40.1424: Independence advisor, requirements.** Establishes the definition and duties of an independence advisor and makes the service mandatory for people in consumer-directed services.

- **37.40.1426: Notice and fair hearing.** Establishes requirements for DPHHS notification of decisions on eligibility, level of care, and services; allows for a fair hearing to contest DPHHS decisions.
- **37.40.1438: Supported living, requirements.** Defines supported living services designed for people with brain injuries or other severe disabilities and the requirements providers must meet to offer these services.
- **37.40.1440: Participation direction.** Establishes requirements for participant direction.
- **37.40.1447: Personal assistance, requirements.** Specifies the requirements for personal assistance services.
- **37.40.1485: Environmental accessibility adaptation, requirements.** Establishes requirements for modifications to a person's home or vehicle; requires that the adaptation be functionally necessary, increase independence and safety in the home, promote the person's functional ability, and be the most cost-effective adaptation available for the person's needs.
- **37.40.1487: Specialized medical equipment and supplies, requirements.** Establishes requirements similar to those in 37.40.1485 for special medical equipment; specifically excludes items of clothing, basic household furniture, most educational items including computers, and items used only for leisure and recreational purposes.
- **37.40.1488: Nonmedical transportation, requirements.** Defines nonmedical transportation, establishes provider requirements, and requires that the transportation be provided only after volunteer transportation services or transportation services funded by other programs have been exhausted.

OTHER DPHHS ADMINISTRATIVE RULES

DPHHS also cited the following administrative rules as governing its Big Sky Waiver policies:

- **37.40.1023: Self-directed Community First Choice services: provider compliance.** Requires Community First Choice providers to undergo DPHHS compliance reviews; specifies the items that will be reviewed for compliance; and sets the compliance standards that providers must meet.
- **37.40.1132: Self-directed Personal Assistance Services: provider compliance.** Requires Personal Assistance Services program providers to undergo DPHHS compliance reviews; specifies the items that will be reviewed for compliance; and sets the compliance standards that providers must meet.
- **37.85.401: Provider participation.** Requires providers of Medicaid-funded services to comply with all state and federal statutes, regulations, and rules.
- **37.85.402: Provider enrollment and agreements.** Establishes the procedures for a provider to become a Medicaid-reimbursed provider; requires that services be provided to Medicaid recipients in the same scope, quality, and duration as they would a member of the public; and prohibits denial of services to Medicaid recipients on the basis of ability to pay or other discriminatory bases.
- **37.85.403: ICD clinical modification and procedural coding system services:** Adopts the medical coding system used by the Medicaid program for billing purposes.
- **37.85.406: Billing, reimbursement, claims processing, and payment:** Allows providers to submit reimbursement claims up to 12 months after the date of service; establishes other procedures for claims submission and payment; limits reimbursement to services or items provided in accordance with all applicable Medicaid requirement; and prohibits a provider's usual and customary charge from exceeding reasonable charge usually charged to all payers. (Incorrectly listed in the DPHHS document as ARM 37.84.406.)

- **37.85.407: Third party liability.** Establishes that Medicaid will not pay for health care services when a third-party has a legal responsibility to pay the costs; provides exceptions; and requires providers to refund the department any Medicaid reimbursement that was provided before a third-party payment was received. (Incorrectly listed in the DPHHS document as ARM 37.84.407.)
- **37.85.410: Determination of medical necessity.** Limits Medicaid reimbursements to medically necessary; allows DPHHS to review medical necessity for an item or service at any time; and allows DPHHS to deny payment or recover an overpayment for a service that isn't medically necessary.
- **37.85.411: Provider rights.** Allows providers to appeal an adverse action by the department.
- **37.85.412: Interpretation of rules.** Requires providers to request and receive a clarification of any rule perceived to be vague before billing Medicaid for a service.
- **37.85.413: Limitations on coding advice.** Makes providers responsibility for selecting the proper billing code when submitting Medicaid claims.
- **37.85.414: Maintenance of records and auditing.** Establishes record-keeping requirements for Medicaid providers and establishes the state's right to audit the records.
- **37.85.415: Medical assistance Medicaid payment.** Establishes when Medicaid will pay for a medical expense.
- **37.85.416: Statistical sampling audits.** Allows DPHHS to use statistical sampling and extrapolation to determine how much it may have erroneously paid a provider; establishes the procedures DPHHS must follow for that process; and provides for an appeal process.

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