

Brief Summary of Changes to Application for Renewal of 1915c Home and Community Based Services

February 26, 2016

Appendix A

1. Previously, Resource Development staff were responsible for all activities related to provider enrollment. In December 2015, a Provider Enrollment Broker was added to execute the Medicaid Provider Agreement. The waiver application has been modified to reflect this change.
2. Data aggregation and analysis for Local Level Complaints and Local Level Incident Reports has been changed from quarterly to annually.
3. The current waiver application states participant/family surveys are conducted on a 3 year cycle and does not specify the reason for the surveys. The new waiver application indicates the surveys will be completed to measure satisfaction and outcome needs. The 3 year cycle was changed to "every 3 years or as needed at the discretion of the department".
4. "Continuous and ongoing monitoring of execution of Medicaid provider agreements" changed to "continuous and ongoing monitoring of participant enrollment" to reflect the changes made in regard to use of a Provider Enrollment Broker.
5. All references to timelines for Agency remediation being completed in a timely manner changed from 30-60 days to 45 days to reflect current practice.
6. Performance measures no longer needed due to changes with the CMS sub-assurances were deleted. (Performance measures for delegated functions are not required if covered by other performance measures associated with other Assurances.)
7. A performance measure to address compliance with HCBS setting requirements was added.

Appendix B:

1. The data sources for performance measures for Sub-assurances a and b changed from electronic client data system reports to records reviews, on-site and records reviews, off-site.
2. All references to timelines for Agency remediation being completed in a timely manner changed from 30-60 days to 45 days to reflect current practice.

Appendix C:

1. Assistive Technology and Support previously identified a \$5,000 cap for assistive technology supports and home modifications. This amount was set in 1998 and restricts modifications to return home. This has been removed and replaced with the State establishes an annual maximum for each of the two service components for Assistive Technology Supports and Home Modifications.
2. Criteria for precluding school attendance by the parent(s)/guardian as a reason for child care to be authorized were updated from post-graduate to graduate studies.
3. The requirement for meals to be delivered daily was removed from the General Service Specifications for Home Delivered Meals.
4. Reference to a broker being used for verification of Provider Qualifications for Transportation Services has been removed to reflect current practice.
5. The bulleted list of crimes that would disqualify a person from being a provider was removed.

6. APS Information was updated to reflect current APS/CPS regulations, policies and practices.
7. All references to timelines for Agency remediation being completed in a timely manner changed from 30-60 days to 45 days to reflect current practice.

Appendix D:

1. Minor verbiage was added to clarify components of the assessment process.
2. Provided clarification that the Plan of Services and Supports must be in place prior to the authorization of waiver services.
3. Provided clarification to include the role of the guardian in regard to Service Plan Development.
4. Clarification was added to the "Nutrition or Hydration Concern" risk to include the client not demonstrating the interest or motivation to eat.
5. In Sub-assurance b, the current measure regarding Plan of Services and Supports (POSS) being developed in accordance with State policies and procedures was divided into two separate measures that address:
 - Files containing a current Plan of Services and Supports
 - Indication that the client or legal representative was involved in the development of the POSS.

This was done in response to CMS' recommendation to avoid the use of compound performance measures.

6. The data source for Sub-assurance d was changed from electronic client data system reports to records reviews, on & off-site.
7. All references to timelines for Agency remediation being completed in a timely manner changed from 30-60 days to 45 days to reflect current practice.

Appendix G:

1. APS Information was updated to reflect current APS/CPS regulations, policies and practices.
2. The performance measure regarding Participant/Family Experience Surveys was deleted due to reliability issues with data.
3. Performance measures regarding incident management were moved to sub-assurance b due to addition of sub-assurances by CMS.
4. A performance measure was added to the new sub-assurance c which addresses restrictive measures not being used.
5. A performance measure was added to the new sub-assurance d which addresses participants being seen by a medical provider.
6. All references to timelines for Agency remediation being completed in a timely manner changed from 30-60 days to 45 days to reflect current practice.

Appendix H:

1. The HCBS Waiver Quality Subcommittee meeting schedule was changed from monthly to at least quarterly (or four times per year).

Appendix I:

1. Performance measures were added/revised to provide specific evidence instead of using the current compound performance measure. This was done in response to CMS' recommendation to avoid compound performance measures.

2. A new performance measure was added to the new sub-assurance b to address billing in accordance with the reimbursement methodology specified in the approved waiver.
3. All references to timelines for Agency remediation being completed in a timely manner changed from 30-60 days to 45 days to reflect current practice.