SECTION 2

MEDICALLY COMPLEX CHILDREN'S WAIVER

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1 General Information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Section I: General Information of the Utah Medicaid Provider Manual*.

1-1 General Policy

Section 1915(c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, a Medicaid funded home and community based services (HCBS) waiver to eligible individuals as an alternative to facility based care. Utah's Medically Complex Children's Wavier (MCCW) was initially approved by the Centers for Medicare and Medicaid Services effective October 1, 2015. Eligibility for to the MCCW is limited to individuals who meet the targeting criteria found in Section 3-2 of this manual. Federal approval includes authorization to "waive" Medicaid comparability requirements. This allows the State to "target" Medicaid reimbursed home and community based services to a limited number of medically complex children. Additionally, the State is authorized to waive certain income and resource rules when determining eligibility for the MCCW.

The State Implementation Plan for the MCCW, approved by CMS, gives the State the authority to provide home and community services to the target group under its Medicaid plan. The State Implementation Plan and all attachments constitute the terms and conditions of the program.

This manual does not contain the full scope of the State Implementation Plan. To understand the full scope and requirements of the MCCW program, refer to the MCCW State Implementation Plan.

Historically, it has been necessary to admit a medically complex child into nursing facility to obtain needed services and supports. The MCCW is designed to offer individuals and their families an option to facility based care. Under the MCCW program, individuals who would otherwise require a level of care provided in a nursing facility (NF) may instead be offered the choice to receive Medicaid reimbursed services at home and in their community. Individuals enrolled in the MCCW are eligible to receive home and community based services in addition to traditional medical services covered by Medicaid.

All HCBS waiver services must comply with federal HCBS settings regulations (42 CFR § 441.301) on an ongoing basis.

1-2 Fee-For-Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid beneficiaries. This manual is not intended to provide guidance to providers for Medicaid beneficiaries enrolled in a managed care plan (MCP). A Medicaid beneficiary enrolled in an MCP (health, behavioral health or dental plan) must receive services through that plan with some exceptions called "carve-out services," which may be billed directly to Medicaid. Clients of the MCCW are specifically carved-out from receiving services through a MCP health plan, but will be enrolled in behavioral health and dental MCPs.

Refer to the provider manual, *Section I: General Information,* for information regarding MCPs and how to verify if a Medicaid beneficiary is enrolled in an MCP. Medicaid beneficiaries enrolled in MCPs are

entitled to the same Medicaid benefits as fee-for-service beneficiaries. Please contact the MCP listed on the beneficiary's medical card for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid beneficiary enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a beneficiary enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a beneficiary's enrollment in an MCP. However, it is the provider's responsibility to verify eligibility and plan enrollment for a beneficiary before providing services. Eligibility and plan enrollment information for each beneficiary is available to providers from several sources. *Therefore, if a Medicaid beneficiary is enrolled in a plan, a fee-for-service claim will not be paid unless the claim is for a "carve-out service."*

1-3 Definitions

Definitions of terms used in general Medicaid programs are available in *Section I: General Information of the Utah Medicaid Provider Manual* (*Section I: General Information*). Definitions specific to the content of this manual are provided below.

Applicant: Is used to refer to the child, or the child's parent or other family member who submits the program application on the child's behalf.

Bureau of Authorization and Community Based Services (BACBS): The organizational unit within the Division of Medicaid and Health Financing that administers the MCCW program.

Client: Is used to refer to the child, or the child's parent, legal guardian or representative

Financial Management Services (FMS): Services offered in support of the self-directed services option. Financial Management Services facilitate the employment of individuals by the waiver client or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution

Home and Community Based Services (HCBS): Are Medicaid services provide through an approved 1915(c) waiver.

Medically Complex Children's Waiver (MCCW): The title of the approved 1915(c) waiver that serves eligible medically complex children.

Nursing Facility (NF): A nursing facility is the facility based service delivery alternative for MCCW clients.

Open Enrollment: Is the period during which the Department accepts waiver applications.

Self-Directed Services (SDS): Clients directly employ individuals to perform waiver services. The client is responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, disciplining etc., of the employees.

State Implementation Plan (SIP): The State Implementation Plan for the MCCW, is approved by CMS. The SIP gives the State the authority to provide home and community services to the target group under its Medicaid plan. The SIP and all attachments constitute the terms and conditions of the program.

Waiver Opening: Is the availability of an individual position on the MCCW program.

2 Provider Participation Requirements

2-1 Provider Enrollment

Medicaid payment is made only to providers who are actively enrolled in the Utah Medicaid Program. Refer to provider manual, *Section I: General Information of the Utah Medicaid Provider Manual* for provider enrollment information.

In addition to completing the general provider enrollment process described in *Section I: General Information of the Utah Medicaid Provider Manual,* waiver providers are required to complete an Attachment A document to assure that providers meet the waiver specific provider qualifications.

3 Client Eligibility Requirements

3-1 General Eligibility

MCCW services are only available to individuals who meet the program eligibility requirements and who are enrolled in the MCCW.

A Medicaid member is required to present the Medicaid Identification Card before each service, and every provider must verify each member's eligibility each time services are rendered. For more information regarding verifying eligibility, refer to provider manual, *Section I: General Information, Verifying Medicaid Eligibility* or to the Eligibility Lookup Tool located at https://medicaid.utah.gov/eligibility.

3-2 Establishing Program Eligibility

To be eligible for the program, the child must meet the following requirements:

1. Be 0 through 18 years of age;
2. Meet nursing facility level of care criteria as defined in R414-502-3;
3. Have a level of disability determined by the Social Security Administration or the State Medical Review Board; and
4. Demonstrate a level of medical complexity based on a combination of need for device-based supports, high utilization of medical therapies, and treatments and frequent need for medical intervention. To determine if a child has the medical complexity and intensity of services required for program eligibility, the child must have had within the last 24 months from the date of program application, or since the birth of the child if the child is less than 24 months old:

a. Three or more organ systems affected; and
b. Must have three out of four of items i. through iv. (listed below):
    i. Involvement of three or more specialty physicians (in addition to the child's primary care physician);
    ii. Prolonged dependence (more than three months) on device-based support to compensate for inadequate organ or system function.
    iii. High utilization and prolonged dependence (more than three months) on medical therapies, treatments, or subspecialty services;
    iv. Frequent need for medical intervention or consultation, such as
        1. 10 or more days spent in an inpatient hospital or skilled nursing facility during the period where the stay was related to the child's complex medical condition; or
        2. 8 or more emergency department or outpatient visits related to the complex medical conditions during the period; or
        3. 20 or more physician office visits, phone calls to the physician, or visits to the urgent care regarding the complex medical conditions during the period.

4 Program Enrollment

Entrance into the program will be managed by accepting application during open enrollment periods to be determined by the Department.

4-1 Open Enrollment Procedures

1. The Department accepts the following means of application during open enrollment periods:
    a. Online application, with a time and date stamp confirming that the application was received within the open enrollment period;
    b. Facsimile, with a time and date stamp confirming that the application was received within the open enrollment period; and
    c. Mail, with the postmark on applications dated no sooner than the first day of the open enrollment period and no later than the last day of the open enrollment period.
2. Incomplete applications, including applications in which required attachments are not submitted, will not be accepted.
3. The number of individuals who may enroll in the waiver program during an open enrollment period is based on the availability of funds.
4. If the number of applications does not exceed the number of available openings when the open enrollment period ends, the Department will enroll all individuals who meet program eligibility requirements described in *Section 3-2 Establishing Program Eligibility*.
5. If the number of applications exceeds the number of available waiver openings, the Department will prioritize entrance into the program based on the complexity of the child's medical

conditions and the critical needs of the child and the child's family as identified in the *Application for Utah's Medically Complex Children's Waiver* (the Application).

a. Applications will be ranked by Department clinical staff based on a score derived from 1) the Application that was completed and submitted by the applicant and 2) the associated required attachments: a history and physical or Well Child Check summary completed by the child's physician within the last 24 months from the date of program application.
b. Prior to enrollment into the MCCW, if Department clinical staff detect a discrepancy between the applicant's responses to the Application and the physician's responses provided on the history and physical or Well Child Check summary, Department staff will attempt to contact the applicant to resolve the discrepancy. To resolve the discrepancy for scoring purposes, the applicant will be required to submit written clarification from the physician. The written clarification must be submitted to the Department with a time and date stamp that confirms the discrepancy clarification document was received within 14 days from the date Department staff attempted to contact the applicant.

    i. Attempts to contact will include calling and emailing the applicant using the telephone number and email address provided in the Application. The applicant is responsible to ensure that the Department has current and up-to-date contact information.
    ii. If the applicant does not provide written clarification from the physician within the 14 day period, the lesser of the two scores for the item that is the object of the discrepancy will be used.

c. If there are multiple applications with the same prioritized score, and the total number of same-scored applications is greater than the number of remaining waiver openings, the Department will assign each application a random number and will create a randomized list. The list will be sorted based on the random number assigned to the application from least to greatest number. The Department will begin selecting applicants at the top of the randomized list and will select applications until all waiver openings are filled.

5 Covered Services

The MCCW offers respite services when delivered pursuant to an approved person centered care plan. Respite care is an intermittent service provided to an eligible individual to relieve the primary care giver from the stress of providing continuous care, thereby avoiding premature or unnecessary placement in facility-based care. Respite care may be provided by a Medicaid enrolled home health agency or through the Self-Directed Service (SDS) model. For program clients, typical utilization of respite care is estimated at approximately three hours per week. Nurse case managers will conduct an assessment and develop a person centered care plan with the client to determine the type and amount of respite needed and to assist

in the coordination of waiver and other services. In addition to waiver services, clients will have access to traditional Medicaid service coverage.

5-1 Types of Respite Services

1. *Skilled nursing respite care* coverage includes an initial RN assessment to establish a new client. Skilled nursing respite care may be provided in the home or other approved community settings.
   a. Qualified skilled nursing respite care providers include:
      i. Medicaid enrolled, licensed home health agencies that employ or contract with registered nurses, licensed practical nurses and home health aides; and are capable of providing respite care services to medically complex children in their homes and other approved community based settings.
      ii. Registered Nurses in the State of Utah under the SDS model which:
         1. Are licensed in accordance with Title 58, Chapter 31b, Part 3, Occupational and Professional Licensing, Utah Code Annotated 1953 as amended (records kept by FMS);
         2. Complete and pass a background and criminal investigation check (records kept by FMS);
         3. Are covered under an individual nursing malpractice insurance policy (records kept by FMS);
         4. Have a current basic CPR certification (records kept by FMS);
         5. Are enrolled with a FMS agency; and
         6. Demonstrate the ability to perform the necessary skilled nursing functions to safely care for the client (Client is responsible for completing this function).

2. *Routine Respite Care* may be provided in the home or other approved community settings.
   a. Qualified routine respite care providers include:
      i. Agency-based providers enrolled as Medicaid HCBS waiver providers.
      ii. Individuals hired by the client under the SDS model who meet the following requirements:
         1. Complete and pass a background and criminal investigation check (records kept by FMS);
         2. Are enrolled with a FMS agency; and
         3. Demonstrate the ability to perform the necessary skilled nursing functions to safely care for the client (Client is responsible for completing this function).

5-2 Self-Directed Services (SDS)

Self-Directed Services (SDS) are made available to all waiver enrollees who elect to participate in this method. Under SDS, clients hire individual employees to perform waiver services. The client is responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, disciplining, etc., of the individual employees.

Financial Management Services (FMS) are offered in support of the SDS option. FMS facilitate the employment of individuals by the waiver client: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution.

The waiver client is the employer of record, retaining control over the hiring, training, management and supervision of employees who provide direct care services.

Under the SDS method, the waiver client submits their staff time sheet(s) to the FMS provider. The FMS provider pays the claims and submits a claim to the Department for reimbursement. All payments are made through the enrolled FMS provider. Payments are made directly to the employee and are not issued to the waiver client.

Financial Management Services Reimbursement

Reimbursement for self-administered services includes reimbursement for all mandatory employer payroll taxes, and workman's compensation insurance premiums. These costs should be paid in addition to the self-administered service rate established between the waiver participant and the employee. For example, if a waiver participant negotiates an hourly wage of $10 per hour with their self-administered services employee, mandatory employer burden costs (e.g. Social Security and Medicare taxes, Federal Unemployment Taxes, and Worker's Compensation Insurance premiums) are paid in addition to the $10 per hour wage. The employee's income tax withholding should be deducted from the negotiated wage.

6 Billing

Refer to the provider manual, *Section I: General Information*, for detailed billing instructions.