Title:	BSW 899-3
Section:	CASE MANAGEMENT REQUIREMENTS
Subject:	CMS ASSURANCES
Reference:	Big Sky Waiver App 02-11-2019; 42 CFR 441.302; ARM 37.40.1420, .1406.
Supersedes:	HCBS 899-3 (01-01-2012)

PURPOSE

DPHHS retains ultimate administrative authority and responsibility for the operation of the Big Sky Waiver (BSW) program by exercising oversight of the performance of waiver functions by case management teams. The Department is responsible for assessing compliance with Centers for Medicare and Medicaid Services (CMS) assurances, and remediation efforts. In order to comply with CMS mandates, case management teams (CMTs) are responsible for reviewing 10% of their caseload at least quarterly for specific performance measures.

NOTE: Refer to BSW 899-2 Internal Audit Requirements for the process and requirements for completing the Internal Chart Audit.

BIG SKY WAIVER ASSURANCES

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

1. Health and Welfare
    a. The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under Big Sky Waiver.
2. Financial Accountability
    a. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector

General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver.

3. Evaluation of Need

    a. The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that a member might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver.

4. Choice of Alternatives

    a. The state assures that when a member is determined to be likely to require the level of care specified for this waiver and is in a target group the individual (or legal representative, if applicable) is:

        i. Informed of any feasible alternatives under the waiver; and

        ii. Given the choice of either institutional or home and community-based waiver services.

5. Average Per Capita Expenditures

    a. The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted.

6. Actual Total Expenditures

    a. The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to members under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these members in the institutional setting(s) specified for this waiver.

7. Institutionalization Absent Waiver

    a. The state assures that, absent the waiver, members served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

8. Reporting

    a. The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver members.

9. Habilitation Services

    a. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are:

        i. not otherwise available to the member through a local educational agency under the

Members with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and

ii. furnished as part of expanded habilitation services.

10. Services for Members with Chronic Mental Illness

a. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to members with chronic mental illnesses if these members, in the absence of a waiver, would be placed in an IMD and are:

i. age 22 to 64;

ii. age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or

iii. age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.