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Center for Medicaid and CHIP Services

CMCS Informational Bulletin

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FROM: Cindy Mann, Director
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SUBJECT: Delay of ICD-10 and Reminder of Section 1915(c) Waiver Instructions

This Informational Bulletin provides information on two topics:

- The delay in ICD-10 implementation, and
- A reminder of the instructions for section 1915(c) home and community-based services waivers regarding actions that result in reductions.

Delay of ICD-10

CMS announced a proposed regulation on April 9 on HIPAA Administrative Simplification. The rule proposes a HIPAA standard health plan identifier and delays required compliance by one year– from Oct. 1, 2013, to Oct. 1, 2014– for new codes used to classify diseases and health problems. These codes, known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes, or ICD-10, will include new procedures and diagnoses and improve the quality of information available for quality improvement and payment purposes.

Many provider groups have expressed serious concerns about their ability to meet the Oct. 1, 2013, compliance date. The proposed change in the compliance date for ICD-10 would give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition to these new code sets.

This proposed rule is the third in a series of administrative simplification rules in the new health care law. HHS released the first in July of 2011 and the second in January of 2012, and plans to announce more in the coming months. More information on the proposed rule is available on fact sheets at http://www.cms.gov/apps/media/fact_sheets.asp. Comments are due 30 days after publication in the Federal Register.

Reminder on §1915 (c) Waiver Instructions and Technical Guide regarding waiver actions that result in any type of reduction

Due to the difficult budgetary situations States are facing, there has been a significant increase in waiver actions, specifically amendments, which seek to reduce services, rates or numbers of waiver participants served. We have recently encountered several situations where

amendment requests to reduce services, rates or numbers of participants in waivers were submitted with retroactive effective dates. Any type of change to a waiver that may result in a reduction needs to be approved by CMS prospectively**.** States are, however, permitted to submit amendments to retroactively increase the unduplicated number of participants back to the beginning of the waiver year at any time during that waiver year cycle.

This guidance does not constitute new policy, but rather highlights guidance from relevant sections of the current Waiver Technical Guide Version 3.5 that was issued in January of 2008. Prospective approvals are always required for new waivers and are also required for renewals that make any reductions to the previously approved waiver. In other words, if a state submits an amendment or renewal to an approved waiver that makes reductions, the reductions are effective for the remainder of the approved period, but cannot be applied retroactively to the waiver's or renewal's approval date.

It is imperative that States submit any action that may result in a reduction with sufficient time to allow for review and prospective approval from CMS. Although CMS will make every effort to work with the State as quickly as possible, such actions must be submitted a minimum of 90 days prior to the anticipated date by which the State would like to implement the change. When a formal Request for Additional Information (RAI) is issued concerning a waiver action, the clock is stopped and only restarted (with a full 90-day clock) once the state responds to the RAI. Therefore, in some instances, the review period necessary may be as long as 180 days prior to implementation if the action requires a second 90-day clock.

Given the critical nature and timing of such waiver actions related to State budgetary plans, we strongly recommend that States consult with CMS prior to the submission. Informal consultation prior to the formal submission may expedite CMS review of the formal submission.

When an amendment would have the effect of reducing the number of waiver participants, the State should also review CMS guidance in Olmstead Letter #4 (located in Attachment C to the instructions of the Waiver Technical Guide and available at the following link: http://www.cms.gov/smdl/downloads/smd011001a.pdf)

Additional information and a link to the Waiver Technical Guide is available at http://www.hcbswaivers.net. Specifically, pages 30-31 of the Waiver Technical Guide, provide more detail about the procedures for submission and review of waiver amendments of various types. If you have any additional questions about this guidance, please contact Mr. Ralph Lollar, Director, Division of Long Term Services and Supports at 410-786-0777 or Ralph.Lollar@cms.hhs.gov.