

**DDD Medicaid Waiver
Frequently Asked Questions
July 1, 2009**

Fees to Access Services

1. Can the waiver pay a recreation pass fee under SLS and CES?

RESPONSE: All waiver participants should explore other ways to access community recreation resources so that Medicaid resources do not have to be relied on wherever possible and this information should be detailed in the Service Plan. For example, the YMCA operates the “Open Doors Scholarship” (YMCA (<http://www.ymca.net/>)) The YMCA is known for their health clubs, but have other community resources as well. The YMCA offers scholarship programs for anyone that needs help paying for a membership to their health club. The YMCA indicates that they won't turn anyone down due to limited income. Additionally, most municipal and county recreation centers offer passes on a sliding scale or provide scholarships to individuals who cannot otherwise afford to pay full price for membership.

The waiver provides a benefit to access a recreation center under certain conditions. Recreation Fees can be claimed under Procedure Code S5199- “FY10-Recreation Fees to Access Prof Service Fee” using the rate of \$1/ unit. The recreation fee code can be used to pay for a pass if it is necessary to receive services that are habilitative in nature including, Physical Therapy, Occupational Therapy, or the professional services defined in the waiver or the Medicaid State Plan. The specific habilitative need must be identified in the individual’s Service Plan and the Service Plan must detail how access to the recreation center will assist in meeting the individual’s identified need. The plan must demonstrate that the most cost effective method was used to determine the payment methodology, eg: daily, weekly, monthly.

Changes to add Fees for Professional Services back into an individual’s plan will not by itself trigger a requirement to come into compliance with Service Plan Authorization Limits.

Respite

2. In SLS, are respite services required to be provided in the person’s home.

RESPONSE: No. Respite services may be provided in a variety of settings including a person’s home or the providers home.

3. My provider just told me they can't pay a provider to do a full day respite, (over 10 hrs) b/c it would violate labor laws b/c the flat rate of 191.06 would be considered payment for more than 10 hrs per day still have to consider the hourly pay which would be too low. I was told our respite provider employees cannot perform that job anymore and of course agencies rates are too high. Not too many families use over night respite but some do and I think it's a nice way to give someone a break and use those, "days" of respite per year, especially with limited units. Can you clarify please.

RESPONSE: Medicaid payments to providers do not in any way dictate how the provider pays their employees/contractors including what hourly wages are paid to their employees or, in the case of CCBs acting as the OHCDs, the rate or method of payment made to subcontractors. Employees or contractors delivering 10 hours or more of respite care can continue to be paid hourly by the provider even though the state pays a per diem rate.

4. Please provide an example of group respite.

RESPONSE: A group respite rate was suggested as providers have developed a variety of settings to meet individual needs. For example, some providers have host homes also providing respite to adults receiving services. The homes can have no more than three adults receiving services at one time. Some providers also have respite homes where respite is provided in a group environment. Again, these providers can have no more than three individuals receiving services.

For children, in some areas of the State, after school programs were developed to meet the needs of school age children needing respite care. The waiver can be used to provide respite care in an age appropriate manner. In either situation licensing and certification requirements must be met.

In addition, when claiming group, even though this is a dollar for dollar claiming, this still applies to the individual service limits.

5. When a consumer is going to receive 24-hour Respite services at the provider's home and paid for through the SLS Waiver, and they also receive Personal Care services when living in their own home, can the respite provider be expected to do the same activities (feed, bathe, transfer, etc) within their respite care and not have these paid for separately?

RESPONSE: Yes. The respite provider should be trained to meet all of the individuals care needs during the provision of respite services including feeding, bathing, and transferring. Personal Care should not be claimed separately during the same period of time.

6. If a consumer is receiving SLS Waiver Respite Services, and as part of that respite they need to be tube fed, can the provider be trained by the parents to feed them via their g-tube while they provide respite, either for 24 hours or for less than 10 hours?

RESPONSE: No. Parents cannot provide training to staff on G-Tubes. The respite provider should be trained using DDD requirements for G-Tube services to meet the needs of the individual requiring tube feeding. The other option would be to access home health services through the Medicaid State Plan for g tube feeding services.

Personal Care

7. Please clarify where cooking, meal planning, meal prep, grocery shopping, and laundry should be billed.

RESPONSE: All of these services should be claimed under home maker. Grocery shopping was inadvertently included under personal care in the waiver. It will be included under home maker when the waiver is amended.

8. Do Community Access Partners who provide assistance/attendance at routine medical appts (vision, dental, PCP visit, nothing extensive) bill for Personal Care under the new definitions?

RESPONSE: If an individual needs assistance at medical appointments in understanding complicated health issues then this service is included under the definition for Mentorship.

9. The new SLS Waiver adds a piece to the Personal Care Services definition that says, “When Personal Care and health-related services are needed, they may be covered . . . “ Could you please define what “health-related services” are in this context, and what could be included here?

RESPONSE: Health related services may include first aide, medication administration, or skilled care that takes place outside of the home and may be covered to the extent that Medicaid State Plan, Third Party Resources or another waiver service is not responsible.

10. The Service Definition in the new SLS Waiver for Personal Care indicates that “when Personal Care and health-related services are needed, they may be covered to the extent the Medicaid State Plan, Third Party Resource or another waiver service is not responsible.” If a person’s health condition (i.e., obesity

with related conditions such as high cholesterol and diabetes) require exercise which can be done in a gym, could someone get paid under Personal Care for assisting the consumer to do routine exercises such as walking, using a stationary bike, lifting weights, etc.? This type of assistance seems to fit the definition of Personal Care as it is intended “to enable participants to accomplish tasks that they would normally do for themselves . . . if they did not have a disability.”

RESPONSE: No. Personal care is generally around activities of daily living such as hygiene. For those individuals who have an identified need for exercise, this would be part of Supported Community Connections.

11. Does the new SLS waiver place any limits on personal care services?

RESPONSE: No, this is based on the needs of the person as identified in the Service Plan not to exceed the Service Plan Authorization Limits and not available through other means.

12. With respect to personal care services delivered by family members in SLS, will there be a maximum number of hours/units plans may have? Any other limits?

RESPONSE: No, this is based on the needs of the person as identified in the Service Plan not to exceed the Service Plan Authorization Limits and not available through other means.

13. May family members delivering personal care services through SLS be paid at least \$5,994 per year (the maximum yearly amount, per the previous SLS waiver)?

RESPONSE: The \$5,994 maximum yearly limit no longer applies as the State is operating under a new waiver effective July 1, 2009.

14. Given an identified need for this, may family members delivering personal care services through SLS, be paid the full value of the plan's authorized limit (i.e., the "Service Plan Authorization limit")?

RESPONSE: The Service Plan Authorization Limit, could be used only for personal care if that is the identified need. A program approved service agency can claim for that service up to the Service Plan Authorization Limit. Payments to the employed family member are between the program approved service agency and the employee and must meet the Dept. of Labor standards.

15. For plans beginning July 1st and later, for personal care services delivered by family members, should we use: FY10-Personal Care Fee

(Procedure Code S5199, \$1.00/Dollar), or FY10 Personal Care (Procedure Code T1019, \$4.78/15 Minutes)

RESPONSE: If a parent has been delivering personal care services, they should continue under the current arrangement with the OHCDS until further direction is provided from the Division. The OHCDS would claim Procedure Code T1019. Procedure Code S5199 should say fees to access professional services. Fees to access professional services are not related to personal care.

Mentorship

16. Is tutoring covered under mentorship?

RESPONSE: Tutoring services should be provided under Specialized Habilitation Services since Specialized Habilitation may serve to reinforce skills or lessons taught in schools. This has been an area of confusion and the State apologizes for earlier direction that tutoring is covered under mentorship.

17. In the Mentorship definition, we see "instructing, providing experiences, modeling, advising". We assume this means that mentorship can be used for people who need one-on-one assistance with socialization or supervision for their mental health needs in the community. Is this correct?

RESPONSE: No. Services to meet an individual's mental health needs are not a benefit of the Home and Community Based Services Supported Living Services waiver (HCBS-SLS.) Supports with socialization are provided through the Supported Community Connections service. The definition for this service includes the following: "These types of services may include socialization, adaptive skills and personnel to accompany and support the participant in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement."

Mentorship Definition: Service provided to participants to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising. This service includes assistance in interviewing potential providers, understanding complicated health and safety issues, and assistance with participation on private and public boards, advisory groups and commissions. This service may also include training in child and infant care for parent(s) who themselves have a developmental disability. This service does not duplicate Targeted Case Management or waiver services such as Day Habilitation. Mentorship is limited to 192 units (48 hours) per year. Units to provide training to participants for child and infant care may be authorized beyond the 192 units per year.

Assistive Technology

18. How may we bill hearing aids in the new SLS waiver? May we bill it as Specialized Medical Equipment? Should we bill it as Assistive Technology? If it must be billed as Assistive Technology, it will be limited by the \$10,000 Cap relating to Limited Duration Services.

RESPONSE: Hearing Aids should be claimed under Assistive Technology. At the time the Hearing Aids are purchased the provider often offers a warranty that can be purchased at an additional cost that will cover a variety of issues. The waiver can cover the cost of the warranty. Up to the persons 21st birthday Hearing Aids are covered through EPSDT. Assistive Technology, Home Accessibility Adaptations and Vehicle Modification falls within the \$10,000 cap for Limited Duration Services. We have had a number of concerns expressed that this cap is too low for hearing aids. We have documented the concerns for future discussions regarding assistive technology limitations.

Day Habilitation

19. SLS Day habilitation and rates. The service definition for Supported Community Connection under Day Habilitation notes that the service "may be provided on a one-to-one basis as a learning environment to provide instruction when identified in the Service Plan." However, the rate structures for day habilitation do not include a rate for individual support. In contrast, Supported Employment rates acknowledge both group and individual services.

- a. Why was a rate for individual service not included in the day-habilitation structure?

RESPONSE: There is nothing preventing the provision of 1:1 services under the current day habilitation rate. The Department understands that there is concern about the adequacy of the rates.

- b. What will be done to ensure consistency across rate categories (e.g. Supported Employment and Day Habilitation) where both group and individual support are clearly acknowledged in the service definition?

RESPONSE: The State is required to standardize rates across a single service category (e.g. Day Habilitation) but not between different services categories (e.g. Supported Employment and Day Habilitation).

Supported Employment

20. We have a consumer who is receiving job development services through the SLS waiver because she is on the wait list at DVR. Her plan was developed prior to

July 2009. If she obtains employment and needs job coaching, will adding that to her plan be a revision that would cause her plan to have to be in compliance with the new annual plan spending authorizations?

RESPONSE: The waiver service is Supported Employment. There is no sub-service for development versus placement. Those are only procedure codes. This would be considered a "technical" amendment so the provider would know the correct procedure code. The individual Plan would not need to come into compliance with the Service Plan Authorization Limits.

21. Given the rule that says the rates and services apply but not in the Service Authorizations (service caps) for plans developed before July 1, 2009 can we continue to use the max units for job development if that was in the plan?

RESPONSE: No, unless the persons SIS level is a 5 or 6. The 120 units is not an individual service limit. The Directive on job development and job placement shows that the rate for job development is broken out by SIS Level. In the January 7, 2009 FAQs on job development and job placement DDD stated, that for SLS, until July 1, 2009, the units for Individual Job Development and the levels for Group SE (job coaching) are determined through negotiation between the provider and CCB and must be based on the complexity of the individual. CCBs were provided SIS levels for everyone in SLS in March. It is expected that this information would have been utilized in plan development as CCBs were told that rates would change as of July 1, 2009 and would be based on the persons SIS level. The rate for Day Habilitation will also be based on the persons SIS level as of July 1, 2009.

Provider Qualifications

22. Who can perform hippotherapy? The description in the spreadsheet that DDD put out is somewhat vague.

RESPONSE: Hippotherapy can be provided by a professional who is certified in that profession. Hippotherapy can be a strategy of choice used by therapists within their treatments (PT, OT or ST). There is a hippotherapy certification exam, if passed, allows a therapist to state that they are a hippotherapy clinical specialist, (a clinician that includes hippotherapy in their practice and has a high level of knowledge in hippotherapy).

23. There seems to be some confusion and conflicting information about "parents as independent contractors." In one area, advocates have heard that parents can't become independent contractors and in other areas we've heard that a parent must be an independent contractor to provide personal needs services. Can you clarify and help us understand how the requirement

(if indeed it is one) can be met? and how to meet that requirement would be helpful.

RESPONSE: If a parent has been delivering personal care services, they should continue under the current arrangement with the OHCDS until further direction is provided from the Division. The Division is working with our attorneys and HCPF to ensure that the direction we provide to parents as independent contractors meets federal and state requirements. As soon as the Division finalizes policies and procedures we will distribute to the system and will arrange a technical assistance training to answer questions from providers and families.

24. At the PAD-CO meeting on 6/23, it was mentioned that Independent Contractors were not able to get Medicaid provider numbers for claiming since they did not meet "agency" criteria. There are ICs that do have their provider numbers. So, this seems to be an area where there is a disconnect

RESPONSE: To submit claims independently, HCBS waiver providers must meet the Medicaid qualifications for the services they choose to deliver according to the requirements set out in each waiver. They must be approved by DDD for service delivery by waiver and enrolled with ACS, HCPF's fiscal agent, by waiver. If a provider meets the criteria and enrolls with ACS, they are not independent contractors. An independent contractor has a contract with the CCB. When an independent contractor works with a CCB, the CCB, as the Organized Health Care Delivery System (OHCDS), is responsible to ensure the contractor meets the Medicaid qualifications. The OHCDS is already an approved Medicaid provider and is enrolled with ACS. Not all independent contractors meet all of the Medicaid criteria to be approved by DDD and enrolled with ACS, but the independent contractor can still deliver services because the OHCDS meets the Medicaid criteria and is responsible for the service delivered by the independent contractor.

Waiver Design

25. What happens when a service is covered through Medicaid State Plan and there are no providers available in the area to provide the service?

RESPONSE: Federal law prohibits the use of waiver funds for services that are available through Medicaid State Plan. When specific examples of this come up, contact Customer Service with HCPF via phone 1-800-221-3943

26. Vision and Dental Services If the cost of vision and dental services are included in the individual's authorization limits-those with lower support levels (which may have nothing to do with eyesight or the condition of one's teeth) could be adversely affected. A Level A person with annual dental/ vision expenses of \$1200 will utilize 10% of her maximum amount

while the costs of the same services for a person in Level D is less than 5%. What can be done to address this potential disparity?

RESPONSE: The Division discussed the option of the vision and dental costs being outside of the Service Plan Authorization Limits. The result would be that Authorization limits A through D would have to be lowered by the amount of the dental and vision costs in order to stay within the budget for the waiver, thus lowering the amount under every limit. This argument regarding funding disparity could be made for other services. For example, under transportation, it could be said that people that live farther from day habilitation, and have higher transportation costs, are adversely affected. The Department will be analyzing all utilization information throughout the coming year, will solicit feedback on how authorization limits are working, and will make adjustments accordingly to how the limits are established if necessary.

27. Limits within a limit. Many families and advocates are perplexed by the infusion of authorization limits based on support levels in the SLS waiver. We understand that waivers often have individual annual expenditure limits that affect everyone served under the waiver-similar to the \$35,000 maximum in this waiver. Some waivers also include enrollment limits. But, to our knowledge this is the first HCBS waiver in our state with internal limits. Can you tell us if there are other Medicaid waivers with similar service-level pre-determined limits? What is the regulatory and/or statutory authority to impose/create Authorization limits within the Waiver?

RESPONSE: Individual service limitations are established in the Elderly, Blind and Disabled waiver. For example, respite hours are limited to 1800 units per year. No other waiver in Colorado has service level pre-determined limits. The Centers for Medicare and Medicaid Services has approved the HCBS-SLS waiver. This indicates to the State that the federal authorities believe that we have the regulatory authority to create authorization limits within the Waiver.

State Funded SLS Plans

23. Will the new rates and spending limits apply to the State SLS Plan? One of the CCB's we work with has been telling State SLS plan consumers that the new rates will apply as of July 1, 2009.

RESPONSE: No. Standardized rates only apply to Medicaid SLS. State SLS will continue to have negotiated rates and be paid on a 1/12th basis.

Appeals

24. Regarding consumers appealing terminations of service – as a provider, if I terminate one to one community access (supported community connector)

services due to the rate decrease, do I have to continue to provide that service if the consumer appeals the termination?

RESPONSE: Direction regarding this topic will be coming out soon.

Claiming Questions

25. The new CES and SLS service categories and rates will go into effect on July 1 and will provider agencies bill the state directly effective July 1.

RESPONSE: Yes, the new SLS service categories and rates will go into effect on July 1, 2009. Medicaid providers have the following options for claims submission:

1. Submit claims directly to ACS, the Medicaid fiscal agency, through MMIS (Medicaid Management Information System). The PASA is responsible for correct submission of claims and completing any follow-up for denied or incorrectly paid claims. Payment is made directly to the provider.

2. Utilize a business/billing agent to submit claims. The PASA contracts with a business/billing agent to conduct the claim submission functions. This may include completing any follow-up for denied or incorrectly paid claims. Payment is made directly to the provider.

3. Subcontract with the Community Centered Board (CCB) as the Organized Health Care Delivery System (OHCDS.) The CCB is responsible to follow-up on denied or in correctly paid claims. Payment is made directly to the CCB. Payment to the provider is made by the CCB according to the agreement made between the CCB and provider in their contract.

26. Do "amendments" to the new waiver mean that after July 1 modifications may be made to category descriptions, caps, rates, etc.?

RESPONSE: HCPF and DDD have not determined what modifications to the waiver may be made. If it is determined that modifications may be made, the waiver amendment will need to be developed, submitted to CMS and approved before changes can be implemented. This is generally a 4 to 6 month process at a minimum. Services will be delivered under the current waiver requirements until then.

