

In an effort to clarify information related to changes required by Centers for Medicare and Medicaid Services (CMS) that are being made in the Colorado developmental disabilities system, the Department of Health Care, Policy and Financing (HCPF); the Department of Human Services Division for Developmental Disabilities (DDD); the State Office of Planning and Budgeting; and representatives of Community Centered Boards (CCBs) have prepared this communication document. The statements below reflect questions or concerns that have been expressed by consumers of services, their families, advocacy organizations, service providers and CCBs.

Questions From Consumers/Families/Advocates

“I’ve Heard That…”

1. CCBs can no longer be service providers. They can only provide case management services.

Response

Colorado’s Developmental Disabilities statute (CRS 27-10.5) and Medical Assistance statute (26-4-621 et. seq.) identify CCBs as the case management agencies and direct service providers.

2. Providers will be billing directly to Medicaid and they won’t be working with CCBs anymore.

Response

Program approved service agencies have the choice to bill MMIS directly, use a CCB as a business agent for billing, or to continue to contract with the CCB as the Organized Health Care Delivery System. No matter what choice is made, CCBs will continue their role as case management agencies and will continue to work with program approved service agencies .

3. There’s no limit to the amount of money for services and I can get any services I need.

Response

The DD waiver will no longer be strictly managed to an appropriation level; however, each consumer will continue to have a plan which will be descriptive of their needs and authorizes services to meet these needs. Needs that can be paid for with Medicaid funding within the nine service areas in the Comprehensive Services waiver will be addressed. It would be a mistake to assume that a plan can be developed that has no limit to the resources required. There will be uniform rates organized in tiers for residential and day services and if a person’s service needs exceed what is available under the highest tier, they theoretically,

should be served in the state institutions (regional centers). A study planned for FY07 will be used to determine the long term rate structure and will also address how people with extraordinary needs should be funded.

4. Providers will get more money because they will be billing directly.

Response

The rates a provider will receive will be based on the uniform rate system that is established and has no relationship to billing directly to MMIS.

5. Providers don't have to follow CCB rules if they bill directly.

Response

The rules are established by the State of Colorado not CCBs and compliance with rules and regulations governing service delivery has nothing to do with billing. The rules are there for the protection of consumers and to outline expectations about services and safeguards and must be followed by everyone. Program approved service agencies maintain program approval status by complying with these rules and failure to maintain program approval will jeopardize Medicaid provider status.

6. The amount of money my son/daughter gets for residential services will be determined by a test and this test has no relationship to their IQ.

Response

A standardized intensity tool will be selected by the State and starting in FY07 it will be used to capture information about the person's level of need for supports. The score on this tool will be part of the information used to determine the Medicaid approved uniform rates that will be available to pay for services. IQ scores are generally only used to determine if a client has a developmental disability.

7. I can choose anyone I want to be my service provider.

Response

A person can choose from any program approved service agencies within the state who is willing to provide the services.

8. CCBs are going to be combined and I'll have to go through a different one

Response

There is no change anticipated in the CCB system structure.

9. My CCB can't help me choose a provider anymore.

Response

CCB case managers will continue to provide families and consumers information about all program approved service providers and other resources that may be available.

10. All the changes affect the SLS program, too.

Response

There are no changes in the SLS program at this time. SLS will be addressed at a later time.

11. There won't be enough money for day programs and my day program will be cut.

Response

At this time it is not known what the specific impact on day programs might be. Day Habilitation is one of the nine waiver benefits, and will have a tiered rate associated with a client's needs.

12. I can only get SLS services if I have a medical need.

Response

Medical necessity is a requirement for all Medicaid funded services as is currently the case. In order to be on the SLS waiver a client must need the level of care provided in an institution, but who can be served safely in the community.

13. If I have a complaint, I'm supposed to call the state.

Response

The best place to start with any complaint or concern is with your case manager. Your case manager will help determine where any formal complaint should be filed and who should respond to your concerns.

14. Supported employment services won't be paid for anymore and I have to go to VR for help with jobs.

Response

It has always been a requirement under the Medicaid waivers to access vocational rehabilitation services for job development and placement. The only way that waiver funds can be used for supported employment job development and placement services is if there is documentation that these services are not available under a program funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

15. If there's an emergency I have to go to the emergency room or hospital.

Response

Certainly if a person is having a medical or psychiatric emergency use of an emergency room or hospital would be appropriate. For waiver enrolled individuals, all program approved service agencies have emergency procedures for any kind of emergency. Historically, the developmental disabilities system and CCBs have used a variety of methods to provide some level of response to some persons in emergency situations who are not enrolled in waiver services. Some of these methods will be impacted by some of the changes and the state is currently evaluating all possible mechanisms to address the needs of people in crisis situations.

16. The waiting list will be managed by the state.

Response

At this point there is no anticipated change to the current practice.

Questions From Providers and CCBs

1. If providers bill directly to MMIS, will there be any funding or other assistance that they may continue to seek through the CCB?

Response

The basic funding that will be available to providers will be determined by the uniform rate system. Any additional fiscal resources that may be available will differ between CCBs. The involvement of case managers in the planning for individuals will remain the same.

2. What are the options for billing? What are the decisions that CCBs need to make in order for there to be expanded options for service providers?

Response

The following options are available to all program approved service agencies:

- The provider may obtain a Medicaid provider number and bill directly to MMIS. The provider will be responsible for the correct submission of the claim, performing any follow-up needed should the claim be denied, and maintaining any and all documentation required by the State to support the billing of the service.
- The provider and the CCB may mutually agree to have the provider contract with the CCB as a business agent (42 CFR 447.10(b)(f)). Under this arrangement the provider would need to obtain their own Medicaid provider number and contract with the CCB to provide the billing functions. This may include any required follow-up to denied or incorrectly paid claims. The business agent contract would need to contain all provisions identified in the CFR and State rules and regulations.
- The provider and CCB may mutually agree to continue their relationship utilizing the CCB as an Organized Health Care Delivery System (OHCDS). In this case all claims are billed under the CCB's provider number and the provider agency is not required to get their own provider number. The CCB would negotiate a rate with the provider, be responsible for billing the services, and following up on any denied or incorrectly paid claims. The provider agency would be under contract with the CCB and would need to maintain documentation per their contract.

3. When will SLS and CES services be billed by providers directly to MMIS?

Response

The CCBs will continue to be the provider of record as the OHCDS for both the SLS and CES programs. Changes to either of these programs they will be addressed at a later date.

4. When providers bill directly to MMIS what will be the CCBs responsibility for verifying the bills? Currently the CCB is required to analyze the bills and compare to services approved, compared to services delivered, compared to the Individual Plan.

Response

If providers bill directly to MMIS any issues related to billing, other than those related to case management functions, will be between the provider and HCPF.

5. What kind of company structure does the “direct billing” apply to, i.e. independent contractors, host homes, typical agencies in the community (Molly Maids), professional staff (behavior or therapeutic)?

Response

Only approved service agencies as defined in rules and regulations of the Division for Developmental Disabilities can bill MMIS directly. By definition, Host Homes are not service agencies and will not bill MMIS directly.

6. Is there any impact on Host Home providers and their tax status if the agency they work for bills directly to MMIS? Currently they receive funds pre-tax acknowledging their status within difficulty of care payments.

Response

There is no impact on Host Homes when the service agency bills MMIS directly.

7. Who will be responsible for oversight and monitoring of services when providers bill directly to MMIS?

Response

CCBs will retain this responsibility.

8. How will the interim rates that are being set be affected once an assessment tool is in place? Is it possible there will be decreases as well as increases in these rates with the tool?

Response

Both increases and decreases in rates are possible when the uniform rate structure is put into place. A person’s rate may be adjusted depending on their changing needs.

9. Will the current due process requirements regarding appeals when a reduction in services occurs apply? What is the plan for addressing this?

Response

Any reduction, termination, or suspension of services in the waiver programs is appealable under Medicaid. Individuals may also utilize the DDD conflict resolution process during the Medicaid appeals process.