

## QUESTIONS FROM CONSUMERS/FAMILIES/ADVOCATES

“I’ve Heard That…”

1. If I take too many vacations, I can’t get services.

### Response

Taking too many vacations does not necessarily place the ability to receive services at risk. It is a waiver requirement that each person must receive at least one waiver service each month. If a person does not receive a waiver service in accordance with the requirements the CCB is required to send the individual, their parent or guardian if appropriate, a notice of the State’s intent to terminate waiver services. The notice will also contain information about the individual’s right to appeal this action by using the Notice of Action (LTC 803) Form.

## QUESTIONS FROM PROVIDERS AND CCBS

1. Is it true that if I do not continue my OHCDs relationship with my CCB, I will no longer receive client referrals?

### Response

When an individual and his/her parent or guardian (whichever is appropriate) are planning to enroll in services, or any time thereafter that they are interested in a change, the CCB, as the case management agency, will provide a list of approved Medicaid providers for each service so that a choice can be made by the individual and their family/guardian. Both the Department of Human Services and the Department of Health Care Policy and Financing will audit for Freedom of Choice compliance.

2. What is the plan for providers being paid when the person receiving services is away from their residence, i.e. on vacation, visiting family, in the hospital, etc.?

### Response

The State recognizes that there is a financial impact to providers when a person receiving services is away from their residence because reimbursement can only be provided if the client is receiving services.

3. We have several service agencies that have elected to bill MMIS directly for services. These agencies provide both Medicaid Comprehensive and SLS services. Would these agencies bill MMIS for the Comprehensive services and bill through the CCB for SLS services, or would they bill MMIS for all Medicaid services?

Response

Agencies that choose to will bill MMIS directly for Comprehensive Services but all agencies will bill through the CCB as the OHCDs for SLS Services.

4. If providers directly bill MMIS for Medicaid services, how will the hours of service allocated and rates in their SLS budget be entered into the PAR system?

Response

Providers will not bill MMIS directly for SLS Services. The process for completing information for the PAR system will continue to be the responsibility of the CCB.

5. What does “negotiation of rates” mean between a provider and OHCDs now that a uniform rate system is being used?

Response

Negotiation means the same thing as in the past. The CCB and the service agency may agree upon a rate to be paid to the service agency for services rendered that may be different than the standard rate paid by the State for services to an individual. This may be a lower rate paid to the services provider in exchange for the performance by the OHCDs (CCB) of certain activities that benefit the provider or it could be a higher rate if the CCB has other resources that may be used to enhance a rate for a particular person. The rate tied to the individual stays the same as the standard rate if a person moves between CCB service areas and any local funding that may have been used is not considered part of the rate.

6. Aren't there statewide standards for how quality assurance activities are to be performed by CCBs? I am confused about how different CCBs can be upholding different standards, yet the program approval result is the same. Will additional requirements currently put in place by CCBs that are over and above the rules be subject to monitoring?

Response

CCBs are required to develop a monitoring plan for monitoring services and supports provided in their service area. Each CCB is required to have a plan which addresses how the monitoring standards will be met. These should include clear procedures for the CCB to monitor (1) incidents; (2) mistreatment, neglect, abuse, and exploitation allegations;(3) disputes; (4) health and safety; (5) services and supports; (6) consumer

satisfaction; and (7) personal needs funds. CCBs are required to monitor practices of service agencies to make sure that they meet the rules and standards of DHS and HCPF. Monitoring of services and supports received by people in the service area must be sufficient to address any health, safety and welfare issues and compliance with applicable rules, regulations and standards.

Without knowing the specific details of any discrepancy between the requirements of the CCB in their monitoring activities and a service agency's perception of the activities, it is not possible to address this question more fully. If a service agency has concerns about CCB requirements they should ask for the relevant citations from state statute, rules or standards, and if this issue cannot be resolved the DHS/DDD or HCPF should be consulted.

7. Will Personal Needs audits be conducted by CCBs when a provider bills MMIS directly?

Response

Yes, Personal Needs audits will be conducted by CCBs just as they have been in the past.