

QUESTIONS FROM CONSUMERS/FAMILIES/ADVOCATES

“I’ve Heard That…”

1. If a service agency is approved in one CCB area that they are approved to provide services anywhere in the state.

Response

Essentially, yes. However, if a service agency is expanding its operation into a new area and this involves setting up an administrative office, some form of DDD approval will be necessary. Likewise, the opening of new group homes will continue to require licensure and the recommendation of DDD to grant the application. Also, if a services agency is billing the MMIS directly, then a separate Medicaid agreement is needed for each location.

2. I have a right to know the specific rate that is assigned to me by the state.

Response

Once DDD has sent out all of the rates to CCBs, CCBs will need a period of time to review this information to assure that no errors were made. CCBs will also need to notify service providers. After this review and notification has been completed, case managers will share this information with those authorized to receive it as it is requested.

3. There are some services I currently get through my SLS plan that will no longer be covered.

Response

There have been no changes made to allowable services under the SLS waiver. Each client’s SLS plan is developed on an individual basis and, assuming that all services identified were allowable, they should continue to be covered. If a service was previously provided under the auspices of the Organized Health Care Delivery System, but is not an approved benefit under the SLS waiver, the service is not a Medicaid reimbursable service.

QUESTIONS FROM PROVIDERS AND CCBS

1. Considering that service providers may choose to bill Medicaid directly, how will local service provider quality assurance oversight be conducted by CCBS?

Response

Irrespective of billing procedures, CCBs will continue to provide quality assurance oversight and case management monitoring responsibilities.

2. After July 1, 2006, what is the process an individual would use to change their CCB for case management services if they are already in services? If they are on the waiting list?

Response

Whether an individual who is enrolled or who is on the waiting list wishes to change case management agencies,, they need to make this request through their existing case manager who will contact the CCB being requested to handle the case management. If the CCB being requested to provide case management for an individual agrees to perform this function, additional arrangements for transfer will take place at the time designated.

3. Are CCBs obligated to provide case management services for those who live in their catchment area or to any eligible person who requests case management support?

Response

Yes, CCBs are obligated to provide case management services for those who are enrolled and who live in their service area. CCBs are also required to provide intake and eligibility determination activities for anyone who requests them who lives in their service area. CCBs are not responsible to provide case management services to people who are not enrolled a Medicaid waiver or enrolled in state funded only services, or who do not reside in the CCB's service area.

4. Who is responsible for approving vision and dental services and who will enter the PAR into the ACS system?

Response

Dental and vision services would be considered when developing the individual's plan of care. The case manager will include the requested amount on the PAR and it will be reviewed and approved by DDD staff when the PAR is submitted to ACS.

5. What if the amount of the PAR is less than the actual cost of the services or item?

Response

If the units of service identified in the PAR are not sufficient to cover the needs of the individual then the case manager would need to submit a revised PAR for review and approval. .

6. Do we know what the Medicaid limit is for glasses and frames? If a person needs special, higher-cost lenses or non-breakable frames, will that additional cost be covered?

Response

The answer is two-fold. A.) The case manager needs to ensure that the individual receiving the glasses is not eligible to receive those services under the Medicaid State Plan. B.) As with all Medicaid services the requirement is to meet the need in the most cost effective and efficient manner. This does not always mean the cheapest but there needs to be a valid reason that can be documented to explain why a more expensive path is chosen.

7. I've read in the April and May Medical Assistance Program Bulletins regarding Medicaid coverage for dental services that there are extraordinary limitations on dental services, with the only reimbursable services being dire emergencies. I'm very concerned that these limits (effective May 2006) will effectively eliminate services to people in SLS. Am I reading this information correctly?

Response

No. The dental services referred to in the Medical Assistance Provider Bulletins are referring to dental services provided under the Medicaid State Plan benefits. It is because of the limitations on dental services to adults under the Medicaid State Plan that the SLS waiver offers dental services that are above those already available from the Medicaid State Plan.