

Technical Questions Re: Medicaid SLS July 25, 2006

1. Will Medicaid SLS funds be drawn down by fee for service instead of 1/12 increments (i.e: a single monthly fee paid for all services provided) in FY 07?

- Yes. Effective July 1st, CCBs will bill by each of the approved waiver services. The approved waiver service categories and billing codes are found on the last page of these responses.

This change in billing methodology means that payments for Medicaid funded Supported Living Services will no longer be billed and paid on a 1/12th basis. Training occurred July 17th, 18th, and 21st for Finance Directors (or their designee) on how this will work in regards to billing. Training to go over PAR and the requirements surrounding it is set for August 3rd for Case Managers.

2. Will the Medicaid SLS cap be reduced for FY 07?

- The SLS waiver limitations are based on the federally approved capacity and cost effectiveness of the waiver. Language in the waiver states that the average cost per person for SLS waiver services is \$11,831 and the maximum cost per fiscal year for any individual may not exceed \$35,000.00 (this includes all waiver costs, including any environmental engineering costs). The amount of funding available to an individual enrolled in the SLS waiver program is based on identified needs that meet specific criteria regarding medical/functional necessity as documented in the person's Individualized Plan, and which cannot be paid for under the Medicaid State Plan or through a third party source. A client who is currently served safely in the community with an amount less than \$35,000 must prove that they are in danger of institutionalization in order to receive more services.

3. Are there changes in Medicaid & Medicare dental/vision coverage 5/1/06 for consumers with concurrent medical status?

- Information about this can be found on HCPF website under Provider Services-Bulletins-4/06 (dental) and 12/05 (Vision). More information on this topic will be forthcoming from our office.

4. Will there be established rates for Medicaid SLS or will we be turning in revised rate sheets as in years past and billing according to those rates?

- For FY 07 CCBs will need to turn in a revised rate sheet to DDD which outlines the rates being paid for each of the SLS and CES services. Services provided may not go beyond the rate established in the rate sheet. Failure to turn in the rate sheet will result in rejected billings.
- Once standardized rates have been established within the Comprehensive services program, the next step will be to establish standardized rates within the SLS and CES programs.

5. Will the CCB continue as the Provider Agency in Medicaid SLS for FY 07?
 - 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 will be addressed at a later date.
6. With the fee for service billing are CCBs allowed to have bulk rates for transportation or do CCBs need to always have a daily rate on the rate sheet? Can CCBs have bulk rates?
 - According to the CCMS Data Collection requirements for the SLS program (revised 7/2001). "**Occurrences** – means the number of episodes, activities, events, items, purchases that are being reported for a service or item which has a one-time cost/price." The first Service example provided is: "**Transportation – one occurrence for each day of transportation provided.**" This clearly identifies that transportation to and from day program under the waiver is reported based on a day in which transportation has been provided. Since the bundled payment methodology is no longer allowable each service has to be billed based on the unit of service, which in this case is a day. If the CCB is not contracting with providers in that manner then they will need to develop a methodology to meet the requirement.
7. Are CCBs allowed to over-serve?
 - CCBs cannot serve more than the number of allocated Medicaid SLS resources in their contract unless a CCB has local funds to match. DDD and HCPF have determined that CCBs will still be able to use local funds to match with Medicaid funds to serve additional people from the waiting list. HCPF and DDD are working on the details to implement this option.
8. Is the CCB contract about the number of people and or will there be a pool of funds?
 - The contract will be based on a number of resources (clients) that the CCB is allocated to serve. CCBs will no longer have dollars allocated in their contracts. Funds will be drawn down per person, per service, billed at the established rates.
9. Will CCB billing rates for services include an "administration fee" component?
 - There is no longer an "administrative fee" component paid to the CCB. CCBs are reimbursed for TCM, Utilization Review and Quality. When the CCB is the provider of service then actual billing rates for services may include appropriate allocable indirect costs that comply with OMB Circular A-122. This should also be the case for billing CES services. When the justification for the rates is submitted to DDD, the rates must be broken down with an explanation of how the CCB determined the indirect cost amount. DDD will monitor these indirect costs to insure that they are not excessive. Once standard rates for the individual SLS and CES services are established this will no longer be required.

HCBS-DD Procedure Code Table				
Supported Living Services (SLS)				
Special Program Code 92	Level	Procedure Code + Modifier(s)		
Personal Assistance Services	15 minutes	T1019	U8	
Professional Services	15 minutes	97530	U8	
Day Habilitation Services	15 minutes	T2021	U8	
Supported Employment	15 minutes	T2019	U8	
Pre-Vocational Services	1 hour	T2015	U8	
Transportation Services	Day	T2002	U8	
Dental – Treatment	Bid	D2999	U8	
Dental – Diagnostic	Bid	D0999	U8	
Vision	Bid	V2799	U8	
Assistive Technology – Environmental Engineering	Bid	T2029	U8	
Home Modification - Environmental Engineering	Bid	S5165	U8	

Note: **Hearing** – Waiver programs may include Medicaid State Plan benefits as extended benefits when the waiver would provide service in excess of what is available through the state plan. Although hearing is an approved service under the waiver the State was made aware by CMS during the re-write of the Comprehensive waiver that there were no restrictions in the State Plan on speech and hearing services. Therefore a code for hearing services has not been established and individuals must receive these services through the Medicaid State Plan.