DDS of CT
Medicaid Home and Community Based Services Waivers
Provider Frequently Asked Questions
Updated – October 2013

APPEALS PROCEDURES

Will the appeals process be explained further in the HCBS Waiver manual?
The appeals process will be clarified further in the Waiver Manual and in DDS Procedure.

What due process rights do individuals have who are denied services or experience a reduction in services? How will individuals and their families be notified of their right to appeal?
The purpose of the waiver is to provide services necessary to enable an individual to remain in or move to the community, and those necessary services are considered in combination with other Title 19, state, and generic services and natural supports. Due process rights include a right to appeal any denial or reduction of a waiver service type, amount and/or duration. Notice of such a decision is made by the DDS Central Office Waiver Unit and includes the information needed to initiate an appeal. This type of appeal is heard by DSS hearing officers. Denials and formal reductions of waiver services are only issued by the DDS Central Office Waiver Unit. A new appeal process was authorized by the legislature in the 2005 session that permits a DDS Administrative Hearing for those individuals who wish to appeal the Priority designation assigned for the DDS Waiting List. Procedures/regulations are under development to implement this legislation.

Is the vendor agency responsible for notifying individuals of their right to appeal?
Appeal rights notification is sent directly to the individual waiver recipient or applicant and/or his/her legal representative. General right to appeal is also referenced in the DDS Waiver Fact Sheet. The provider agency has no designated role or responsibility to inform individuals of waiver rights.

How are individual's assigned funding ranges? Will providers have input into these decisions?
Individuals are assigned funding ranges based directly on the results of the Level of Need Assessment. The costs of a particular provider are not factored in to the funding allocation. The need for intensive staffing is reviewed by a DDS Utilization Review committee using methods developed by an outside consultant. The Level of Need tool and funding methodology is under further refinement with the guidance of a Steering Committee comprised of all DDS stakeholder groups.

How will DDS ensure that appeals regarding service decisions are made objectively?
Appeals regarding the final amount of approved funding and/or services under the waiver are heard by DSS Hearing Officers.

AUDITS

In what ways will the vendor and DDS work together during a CMS audit?
DDS will be providing continuing guidance and information regarding acceptable documentation, billing and financial accounting practices. DDS will provide notice and information regarding how and what information will be sought prior to any CMS audit.

When will CMS audit the DDS HCBS Waivers?
CMS audits may occur at any time, by CMS, by the Office of the Inspector General or by the Department of Health and Human Services. CMS is initiating routine annual quality reviews that may or may not include an on-site audit. Vendors/Providers are expected to adhere to the

elements found in the signed Provider Enrollment Agreements with DDS and DSS, and to all Provider Qualifications requirements outlined in the waiver(s) for each service delivered.

BILLING

Will services be billed in units, hours, or a combination of both?

Services will be billed in the appropriate unit for the service. For example, IS Habilitation, Personal Support, Vocational Supports will be billed in hours, respite will be billed either per hour or per diem, and transportation will be billed in either mileage or per trip.

When a person receiving services is hospitalized, is the provider paid for the person's services? If so, does this mean that a provider can no longer provide supports to the person at the hospital or a home-bound day service for people in Long Term Care (LTC)?

A waiver service cannot be billed while a person is in another Medicaid residential facility such as a nursing home or hospital if Medicaid is the payer for that stay. Residential waiver rates include a vacancy % in the rate to take into account occasional absences from a home. This, in turn, covers the costs to the provider to maintain staffing and provide those supportive activities without billing for that particular day. DDS may choose to provide state funded supports in other cases. Individual circumstances should be discussed with the Regional Office.

MEDICAID ELIGIBILITY

Can an individual receive DDS services without being a Medicaid recipient? What happens if the individual does not qualify for Medicaid? What happens if an individual does not want to apply for Medicaid?

Substantive DDS services will be provided through the HCBS waivers, requiring Medicaid eligibility. Individuals who do not qualify for Medicaid may be eligible for state funded family support. Individuals who are not eligible for Medicaid due to income or asset limits will be assisted to meet the Medicaid guidelines so they may be eligible for waiver enrollment in the future. Individuals who decline to participate in the Medicaid waiver will not be eligible for DDS day and residential services. DDS will work with the individuals to ensure they understand the consequences and options. If a person continues to refuse they will be denied access to new services and will jeopardize the continuance of existing services.

Will the vendor be required to return waiver funds for individuals who become ineligible for Medicaid?

Vendors will not be required to return payments for individuals whose Medicaid eligibility was later found to be denied. DDS assures those services and payments are not billed to Medicaid, and assists the individual with re-establishing Medicaid eligibility as needed. DDS should be immediately notified by a vendor if the vendor learns the person has lost Medicaid eligibility (CLA and CTH providers receive Title 19 correspondence, and should respond in a timely manner to ensure Medicaid eligibility is maintained.)

Who will monitor whether an individual is qualified to receive services or not? DSS often temporarily disqualifies individuals because they have not had time to review re-determination information. What happens during this temporary" non-qualifying period"?

DDS will monitor eligibility re-determinations. Services can continue during an interruption, but DDS will not bill for FFP during that time period.

Will the requirement to be on the Medicaid Waiver effect family's ability to keep their child (as disabled child) on their private health insurance as well?

No, Medicaid is the payer of last resort and does not have to be used for health care if private insurance is maintained. Each private employer's health plan policies may differ, however, regarding eligibility to carry adult children on parent policies.

What will happen to those individuals already being served who do not qualify for the Medicaid Waiver (people who "live their dream" are competitively employed with benefits, 401(K), etc. do not meet criteria for the waiver currently. Their salary supports them but there isn't enough for them to pay for their services?)

Individuals who are not eligible due to income or asset guidelines will be assisted to work towards Medicaid eligibility. Recent legislation will permit individuals who are working to enter into the Medicaid for the working disabled program and be qualified for waiver enrollment, which will increase the income and asset limits substantially, allowing a large number of individuals to then enroll in the Medicaid waivers.