

**Supported Living Services Waiver
Frequently Asked Questions
May 1, 2009**

The Division for Developmental Disabilities (DDD) has been soliciting public feedback since the Medicaid waiver reform began in 2006 through public meetings with self-advocates, advocacy organizations, Medicaid Steering Committee and numerous other public forums. Additionally, we have received other verbal and written comments. During this time, the DDD has provided information and responses in many different ways, but the level of complexity and amount of change that has been required in order to come into compliance with federal requirements has caused some significant confusion about the impact to self-advocates, families, providers and many others regarding the changes coming to the waivers. Changes to the Comprehensive Services (HCBS-DD) waiver were addressed first, and now we are in the middle of making the needed changes to the Supported Living Services (SLS) and Children's Extensive Support (CES) waivers.

The DDD is aware of the concerns about the limited time for public input to the publication of the recent Medicaid waiver applications. While the complexity and amount of change can be overwhelming for everyone, especially self-advocates and families, we are committed to communicating with everyone on a regular basis. We apologize for the limited time for public input to the publication of the waiver, however, the currently approved waivers will end June 30, 2009, and we were required to submit the renewal application by April 1 at the latest.

We have heard your concerns and urge you to continue to communicate with us. We can assure you that your comments do matter and we have made numerous changes to the waiver applications prior to submission to reflect that feedback. In the future, the timeframes will be amended to ensure that self-advocates, families and others have the opportunity to review and understand all that they are hearing and reading.

Below, we have summarized some of the most common questions that we have been receiving and have provided a response.

Respite

Question. Please explain the proposed yearly cap of 1880 units and 30 days of respite. Can this cap be set up to allow consideration for exceptions on a case-by-case basis.

RESPONSE:

Respite shall be billed according to a unit rate or daily rate whichever is less. The total amount of respite provided in one plan year may not exceed 30 days and 1,880 units per plan year. If an individual receives more than 10 hours of respite in one day it will be billed as one day. The state has added an exception to allow for approval of a higher amount based on a documented increases in behavioral or medical needs as reflected in the behavior plan for behavioral needs or in the medical records for medical needs. In the event there is an identified need for additional respite units, the CCB will submit a request to the DDD program specialist requesting additional respite units. We will set up a system

to assure families that need to get special approval for more hours will not experience a delay in the availability of services.

Respite Services Rate

Question. I am concerned and a bit confused with the personal assistance rate changing to a respite day rate of over 7.5 hours.

RESPONSE: In the teleconference with providers and families, it was presented that 7.5 hours would constitute a full day. However, the number of hours that constitutes a full day has since been changed to 10 hours. Respite shall be billed according to a unit rate (i.e., 15 minute increments up to 10 hours) or a daily rate (i.e., from 10 to 24 hours) whichever is less. The total amount of Respite provided in one plan year may not exceed 30 days and 1,880 units per plan year. This means that Respite will be limited to 30 full days per year (i.e., a full day is any service period of 40 units (10 hours) or greater), **AND** an individual may receive up to 1,880 units (470 hours) of respite for those days in which the total hours were less than 40 units (10 hours).

The DDD has added an exception to allow for approval for more units based on documented increases in behavioral or medical needs as reflected in the behavior plan for behavioral needs or in the medical records for medical needs. The DDD will work closely with Community Centered Boards in setting up a system for requesting additional hours to ensure that families whose needs exceed the limits will not experience a delay in the availability of services. The DDD is still finalizing the unit and daily rate for respite services and anticipates release of these rates in May. We urge families to continue to communicate with their Community Centered Board so that we can work together to ensure appropriate levels of services are provided.

Mentorship

Question. Mentorship has a cap of 192 units and tutoring is included in this amount. There is a specific exception for consumers who have child and infant care on their plan. Would it be possible to extend this to other consumers if recommended by the Interdisciplinary Team?

RESPONSE: The DDD has been required to more narrowly define each of the waiver services. However, both tutoring and infant care are still available.

The primary purpose of Mentorship is to promote self-advocacy through methods, such as instructing, providing experiences, modeling and advising. Within the definition of Mentorship is training in child and infant care for parent(s) who themselves have a developmental disability. Mentorship may be authorized beyond the 192 units (48 hours) per year when the additional need is for training to participants for child and infant care. However, exceptions beyond that are not available at this time.

Tutoring services may still be provided under Specialized Habilitation Services since Specialized Habilitation may serve to reinforce skills or lessons taught in schools.

Service Plans

Question. *We do our staffing two months prior to the start date. Our July start dates have staffings in May, which is before the publication of rates and procedure codes. How will the "Phase In" work?*

RESPONSE:

Available Now – The Support Levels for all individuals in the SLS waiver are available from the CCB case manager. Each individual in HCBS-DD (Comprehensive) Services and Supported Living Services programs has been assigned a Support Level based on the results of the individual's Supports Intensity Scale (SIS) assessment and other supplemental rating factors. The funding amounts associated with each of the six Support Levels are available to everyone in May, so a family will be able to know the amount of funds associated with purchasing needed services and supports for their family member.

Between April 1, 2009 and June 30, 2009 – For Individualized Plans (also known as Service Plans) developed between April 1 and June 30 whose implementation date will not be until on or after July 1, 2009, they will be developed using the new service definitions that have been distributed in anticipation of the new waivers being implemented. The plans cannot include any of the waiver services that will be discontinued as of July 1, 2009. These Service Plans will not need to be amended until their next regularly scheduled Service Plan review date or at such time that a participant experiences a life change that creates a significant change in the his or her needs which prompts the need for an amendment to the Service Plan. If a Service Plan is being amended between April 1 and June 30 for immediate implementation of a service change under the current waiver, these plans must have an end date included for those services that will no longer be available effective July 1, 2009 and they should include any replacement services based on the new waiver service definitions, as applicable. In both scenarios above, the use of the Service Plan Authorization Limit and Individual Service Limits will not be implemented until Service Plan meetings that actually take place on or after July 1, 2009.

On or around May 15, 2009 – The DDD will publish the standardized rates for the Supported Living Services (SLS) and Children's Extensive Support (CES) waivers. For those services that are the same as in the HCBS-DD (Comprehensive) Services waiver, the rates will be the same. For those services that are unique to either SLS or CES, the new rates will be published as well. The DDD will notify the system about the amount of funds (i.e., Authorization Limits) associated with each of the Support Levels from 1 to 6 that will be available to purchase services and supports. The DDD will issue a specific communication that explains in detail the process for family members who provide services to their family as an independent contractor.

June 30, 2009 – The current federally approved Medicaid waivers (HCBS-DD, HCBS-SLS and HCBS-CES) will end.

Effective July 1, 2009 – Some waiver services will no longer be available, however, there will be some services that will simply be provided under a different service category. For

example, Supported Living Consultation (SLC) will no longer be available, but some of the same duties previously performed under SLC will be available under mentorship.

Service Plan Authorization Limits

***Question.** Please explain the service authorization limit and how the SIS is used to determine the amount of money available to an individual.*

RESPONSE:

The DDD has been required by the federal Centers for Medicare and Medicaid Services (CMS) to use a standardized method to determine the level of need of waiver participants. Each individual in the HCBS-DD (Comprehensive) and Supported Living Services waivers has been assigned a Support Level based on the results of an individual's Supports Intensity Scale (SIS) assessment and other supplemental rating factors. The funding amounts associated with each of the six Support Levels will be available to everyone in order to know the amount of money available to purchase services and supports for an individual receiving services.

Supported Living Services program: the four spending cap levels (A-D) match to the six SIS Support Levels (1-6) as follows:

- Support Level 1 = Authorization Limit "A"
- Support Level 2 = Authorization Limit "B"
- Support Levels 3 & 4 = Authorization Limit "C"
- Support Levels 5 & 6 = Authorization Limit "D"

By the end of May, the DDD will notify the system about the amount of money (i.e., Authorization Limits) associated with each of the Support Levels from 1 to 6 that will be available to purchase services and supports. These Authorization Limits must remain within the overall cost effectiveness of the Medicaid waivers.

SLC

***Comment.** We are concerned that the Supported Living Consultation (SLC) function was eliminated. Please explain how services previously provided under SLC will be delivered.*

RESPONSE: It is not so much a matter that Supported Living Consultation is going away, rather, that the duties are more appropriately being assigned to the correct service category. While the service category of Supported Living Consultation itself will no longer be available, assistance with decision making, planning daily activities and direct assistance to access community resources and/or services will still be available under other service categories including mentorship and day habilitation. Mentorship can be accessed to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising. In addition, Mentorship includes assistance in interviewing potential providers and assistance in understanding complicated health and safety issues. CCBs will still be able to be a service provider.

Community Access

***Question.** How will clients receive Community Access (CAS) services? We found no definition that covers going out in the community with a provider.*

RESPONSE: Supported Community Connection (SCC) has taken the place of Community Access (CA) Services. In looking at the side by side comparison for SCC and CA, you will see that everything in the CA definition is included in the SCC definition. The service definition for SCC incorporates more guidance around what the intention of the service is. Recreation has never been part of the definition. Supported Community Connection is available under the SLS waiver to support the abilities and skills necessary to enable the participant to access typical activities and functions of community life such as those chosen by the general population, including community education or training, retirement and volunteer activities. These types of services may include socialization, adaptive skills and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement.

Communication

Question. Who is going to inform the families of all the changes? When is this going to happen? How is it going to happen?

RESPONSE: On April 27, 2009, a detailed letter and outline of the changes was distributed to the system and posted on the DDD website at <http://www.cdhs.state.co.us/ddd/WhatsNew.htm>. The DDD will be distributing regular communications to families and the system in the coming months.

Dental and Vision

Comment. Dental and vision are now included in the cap. This puts a consumer in the position of deciding whether they want to go to day program or have their teeth fixed. This is a health and safety issue.

RESPONSE: Adequate provision of Dental and Vision services have historically been a difficult issue in the developmental disabilities system and there is no easy solution. While the SLS waiver provides some flexibility for an individual to mix and match the available services to meet his or her needs, there is still an overall Service Plan Authorization Limit for each person. The DDD understands the concerns expressed but cannot change the waiver to exclude these costs in the Service Plan Authorization Limit without going outside of the overall cost effectiveness of the waiver.

Trager Therapy

Comment. During teleconference covering proposed rates & an overview to the SLS and CES waiver we asked that if Trager would be covered under the new waiver. The trager approach developed by Dr. Milton Trager is a system of gentle, passive, rhythmical movements performed with great sensitivity on a padded table. The practitioners use soft hands and their whole body to generate movements that communicate a feeling to the autonomic nervous system that allows

the receiver to feel a letting go of movement/ mind patterns that are either painful, uncomfortable, or ineffective.

RESPONSE: Trager therapy will be covered under massage therapy, so long as the provider is licensed, certified, registered and/or accredited by an appropriate national accreditation association in massage therapy and the service is related to an identified medical or behavioral need. The need for massage therapy service must be an identified need in the Service Plan.

Day Habilitation/Supported Employment

Comment. Please ensure that SLS Service Plan Authorization Limits (slide 25) has some way to accommodate lower support level individuals who utilize their funding for work related services so that the new system does not reduce their funding and make them unemployed. With the standardized PARS/rates for services, we are concerned that individuals served will end up getting less service than in years past. The new waiver would allow less flexibility, and it seems like more money will be needed to pay for the same service.

RESPONSE: There is some loss of individualization with the combination of a fee for service system and uniform State set rates that the DDD is required to use. The DDD has formed a Rates Work Group to analyze current rates and services and to develop recommendations to help limit negative impact on individuals, families and providers. By mid May, the DDD will notify the system about the amount of money (i.e., Authorization Limits) associated with each of the Support Levels from 1 to 6 that will be available to purchase services and supports.

Case Management

Comment. We are concerned that changes in case management will result in less services and supports for individuals enrolled in the waiver. Please provide a summary of the anticipated changes to case management.

RESPONSE: Case Management reimbursement is being changed from a flat fee per participant per month to reimbursement per 15 minutes of time spent providing case management services. This change should allow for adequate financial support of case management activities to appropriately assist participants in finding and selecting providers and coordinating needed services. Additionally, the DDD will be working with case management agencies to streamline the provider selection process and make available a constant updated list of available and qualified providers on the DDD website.

Annual Cap

Comment. After attending the teleconference on the changes to the Medicaid Waiver system in Colorado, I have some real concerns for not only my daughter, but all people who are on these waivers or on the waiting list to get one. I don't believe the figures for annual cap amounts for the SLS waiver are realistic.

RESPONSE: The maximum annual overall spending cap under the current SLS and CES waivers is \$35,000. The new waivers propose no change to the annual overall spending cap.

Individually assigned Support Levels may increase or decrease what a person has been receiving in the past. However, the Support Levels are based on the result of the Supports Intensity Scale, plus some additional assessment factors. The use of the standardized assessment tool is intended to equitably determine the level of need of people in a manner that is compliant with federal regulations. The DDD has not received any new funding to expand the program, so the implementation of the Support Levels must be done within available funds.

Durable Medical Equipment

Question. Can disposable personal wipes be covered under the new SLS waiver?

RESPONSE: There are two options for obtaining disposable personal wipes. Disposable Personal Wipes are covered under the SLS Waiver when they are due to incontinence because the Medicaid State Plan specifies that they are not covered. The Medicaid State Plan only covers wipes when they are necessary for treatment of a medical condition, such as a skin breakdown. For more detail regarding what is a covered medical supply under the Medicaid State Plan please see the following link.

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1239160369298&ssbinary=true>

Provider Monitoring

Comment. I have concerns about changes in the monitoring of providers and how the State will continue to ensure programs are beneficial and that the staff are safe, trained, and dedicated.

RESPONSE: The CCB case manager is still responsible for making sure that the services an individual receives are beneficial. The case manager should have regular contact with the participants on his or her case load and is required to report any problems with a provider to the DDD. The case manager is also responsible to refer participants to only those providers which are Program Approved Service Agencies (PASAs,) approved by the DDD. The DDD regularly surveys PASAs to ensure appropriate service delivery and also conducts a survey if there are any problems to determine if corrective action is required. If a person receives services from an agency that operates under contract with the CCB, the CCB is still responsible to make sure the provider meets all program quality standards.

Medicaid State Plan

Question. At the presentation the State spoke about Medicaid State Plan paying for some services and Medicaid SLS waiver paying for others. Is this new or has it always been handled this way?

RESPONSE: This is not a new requirement. However, in the past this requirement may not have been strictly enforced across the State. The federal Centers for Medicare and Medicaid Services (CMS) does not allow for payment of services that are “otherwise available” through the

Medicaid State Plan. For example, Physical Therapy and Occupational Therapy are available through the Medicaid State Plan, and therefore, that is the only means of Medicaid reimbursement for those services.

Transportation.

Question. Please expound on transportation for Supported Employment (SE). Is it allowed? When is it allowed? What if no natural supports or public transportation are available? What if it is unsafe for a client to get themselves to work (via bike or walking)? What if a medical condition is present? Is SE considered Supported Community Connection? Under what circumstances would a client have to pay for their own transportation?

RESPONSE: Transportation services are provided in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the Service Plan. Transportation services under the waiver are offered in accordance with the participant's Service Plan. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized. However, if an individual's Service Plan specifies transportation is necessary to gain access to supported employment waiver services then it is allowed. Transportation to and from day program (work) is reimbursed based on the applicable transportation band. Transportation in addition to day program is limited to 10 trips per week reimbursed at transportation band one.

Question. Can an additional tier for transportation be considered for SLS? There is no public transportation available and we may not be able to continue to provide transportation for individuals since even the current cap does not allow us to recover costs.

RESPONSE: The DDD understands these concerns regarding transportation in rural areas. However, at this point we cannot include an additional transportation band. The DDD will continue to monitor this rate and access to transportation services closely.