COLORADO
Department of Health Care Policy & Financing

INFORMATIONAL MEMO

INFORMATIONAL MEMO NUMBER: HCPF IM 19-025

TITLE: OVER COST CONTAINMENT PROCESS AND FREQUENTLY ASKED QUESTIONS

SUPERSEDES NUMBER: N/A

ISSUE DATE: MARCH 15, 2019

EFFECTIVE DATE: MARCH 15, 2019

DIVISION AND OFFICE: BENEFITS AND SERVICES MANAGEMENT DIVISION, OFFICE OF COMMUNITY LIVING

PROGRAM AREA: OVER COST CONTAINMENT

APPROVED BY: CANDACE BAILEY

KEY WORDS: OVER COST CONTAINMENT, FAQ, EQHEALTH

HCPF Memo Series can be accessed online: https://www.colorado.gov/hcpf/memo-series

Purpose and Audience:

The purpose of this informational memo is to provide answers to all stakeholders to frequently asked questions to the over cost containment (OCC) review process for specific Home and Community Based Services (HCBS) waivers.

Background:

Beginning December 2018, eQHealth is the Department's designated reviewer for Over Cost Containment (OCC) requests. Case Managers must create an account in the eQSuite in order to submit a request. Below is an overview of the process, case manager expectations, and answers to common issues

Information/Procedure: Frequently Asked Questions:

1. *Question: What is Over Cost Containment?*

Answer: Over Cost Containment (OCC) is a review of requested Home and Community Based Services (HCBS) and Long-Term Home Health (LTHH) services. A review by the Department, or its designated reviewer, is required when the average daily cost of HCBS and LTHH services is $285 or more. The review is conducted to ensure there is no duplication of services and the services requested reflect the needs identified in the assessment.

2. *Question: How is OCC determined?*

Answer: OCC is the total cost of HCBS and LTHH services, divided by the number of days in the certification period. That provides the average daily cost of services. If that number is $285 or more, a review is required.

3. *Question: What waivers does this OCC review apply to?*

Answer: OCC requests are not required for all waivers. An OCC review is required for the Elderly, Blind and Disabled (EBD), Brain Injury (BI), Community Mental Health Supports (CMHS), and Spinal Cord Injury (SCI) waivers. The Children's Extensive Supports (CES), Children's Home and Community Based Services (CHCBS), Children with a Life Limiting Illness (CLLI), Supported Living Services (SLS), and Developmental Disabilities (DD) waivers have other spending limits in place to monitor costs.

4. *Question: What do I need to submit when making an OCC review request?*

Answer: Always submit a copy of the PAR and any supporting documentation for the request. Incomplete information may lead to a denial.

- Consumer Directed Attendant Support Services (CDASS)
  - PAR (dummy PAR or screenshot from the Bridge)
  - Task worksheet and explanation of allocated time
  - Allocation worksheet
  - Doctor orders, and any other supporting documentation

- In-Home Support Services (IHSS)
  - PAR (dummy PAR or screenshot from the Bridge)
  - Agency care plan
  - IHSS calculator
  - Doctor orders, and any other supporting documentation

- LTHH
  - Signed and completed LTHH PAR
  - Agency 485
  - Physician Orders

5. *Question: I am requesting a service be approved over the allowed limit, such as respite for the CES waiver. Do I need to send this request to eQHealth?*

Answer: No, you do not need to send a request to eQHealth in order to receive approval for specific service authorizations. For example, if you are seeking Department approval for additional respite units above the set threshold, you will continue with the same process for approvals, contacting the benefit specialist over that particular benefit.

6. *Question: Why did I receive a denial from eQHealth?*

Answer: One of the most common reasons for a denial is for lack of information. As part of the submission, you are required to submit all necessary and supporting documentation. eQHealth will respond to the request stating more information is needed; if the required documentation is not provided subsequently, a denial will be issued, and a resubmission will be required.

7. *Question: What other reasons might I see a denial?*

Answer: The level of services requested do not meet the needs outlined in the assessment. For example: the IHSS Care Plan Calculator lists all skin care as skilled care; however, there is no skin integrity issue or open wounds listed anywhere in the assessment. Therefore, there is not a documented need for skilled skin care. In order to resolve this, either the assessment must be updated to ensure the task meets the definition, or the task can be changed to personal care.

8. *Question: Since I received a denial on the request, can I resubmit my request?*

Answer: Yes! You can always resubmit a request and ask for it to be reviewed again if additional information is added, the assessment has been revised, or there are additional factors to consider.

9. *Question: I am completing a revision to an existing PAR that I received OCC approval at the start of the certification period, do I need approval again?*

Answer: Yes. If you are revising, adding services, or changing delivery options (example: CDASS to IHSS) you must receive approval. In your request, please note to eQHealth that you are submitting a revision and what changes are being made, i.e. adding a new service or adding units to an existing line.

10. *Question: I have submitted a request to eQHealth for review, but I don't have approval yet. Can the provider still provide services and bill?*

Answer: A PAR may not be billed against until it has received OCC approval. If the provider is rendering services prior to receiving approval, they do so at the risk of not receiving payment. Providers cannot bill off a dummy PAR or screen shot.

11. *Question: I completed a Continued Stay Review (CSR) and sent the OCC review request to EQ Health. The PAR start date has already passed, and I have not received approval from EQ Health yet, what do I need to do now?*

Answer:

- Continue to work with EQ Health on the OCC approval process. To facilitate the review, ensure all documentation is provided to EQ Health when the original request is submitted.

- Participants using CDASS are the employer of record for their attendants. They require an approved PAR on file with their FMS vendor by the 15th of the new certification period for payroll to be completed timely. The case manager must work with EQ Health to review and approve the OCC request before the new certification period/PAR start date. For circumstances where the submission or approval is delayed, and attendant payroll will be impacted, submit the OCC request to EQ Health and request the services to be approved while the review is being completed. Once the determination is completed the case manager will follow up on any changes needed to the services.

- A change in service authorization requires a notice of adverse action (803). If it is determined that the services requested on the PAR are not substantiated by the members assessment and case management documentation, the case manager will be referred to change the services. The member must be sent an 803 which outlines the service change and the members appeal rights. The service level previously authorized for the prior certification span will be continued into the new certification span until the effective date of the 803 is reached. In the event of a timely appeal filed with Office of Administrative Courts, the member can request to continue the current service level until the appeal process is completed.

12. *Question: eQHealth said that part of my request was denied. I submitted documentation. What do I need to do?*

Answer: It is possible that the request does not match the assessment. For example, if the request is for 30 minutes for bathing daily, make sure the frequency and duration is outlined in the assessment. Another possibility is that the task(s) do not meet task definitions. In this case, please review the assessment to ensure that the frequency, scope, duration and level of assistance is provided.

13. *Question: What else can I do to ensure my request is processed quickly?*

- When sending eQHealth a screenshot of the PAR, please ensure you send the screenshot with the line items and the information in the top panel. eQHealth cannot conduct a review with incomplete information.

- It is helpful to provide a narrative with your request. The narrative can help to describe to the reviewer the need for requested services or highlight an update or change to the 100.2.

14. *Question: My client went into a Nursing Facility or passed away and I am trying to end the PAR, but I keep getting an error message. What do I do?*

Answer: OCC is calculated based on the cost of services divided by number of days in the service plan. When you end a PAR in the Bridge, the units remain the same, but the number of days decreases, creating a higher dollar amount per day. When closing the

PAR, please revise the number of units in addition to revising the date span for the services. If you continue to experience issues, please send an email to the LTSSOCC@state.co.us with the PAR number, dates services are to be ended, and your specific request for assistance. Please write in the subject line of your email "Bridge PAR Assistance Required".

15. *Question: I sent in my request to eQHealth, received approval, submitted the PAR, and it is now pending or suspended for state approval. What do I do next?*

Answer: If you have keyed the PAR and submitted it to the InterChange and the status shows as "Pending State Approval", "Suspended" or "Work in Progress", please send an email to the LTSSOCC@state.co.us with the PAR number and your specific request for assistance. Please write in the subject line of your email "Bridge PAR Assistance Required".

16. *Question: What is the difference between Over Cost Containment and the CHCBS Cost Containment form?*

Answer: The Over Cost Containment process is for waiver services and applies to the Elderly, Blind and Disabled (EBD), Brain Injury (BI), Community Mental Health Supports (CMHS), and Spinal Cord Injury (SCI) waivers. It does not apply to the Children's Home and Community Based Services (CHCBS) waiver.

The CHCBS Cost Containment form only applies to the CHCBS Waiver. This document demonstrates the expected state plan **and** waiver services that a child on the CHCBS waiver will receive during the certification period. These forms need to be submitted at the time of a child's initial enrollment onto the waiver, and any time that the expected cost per day changes by +/- $50 per day. This Cost Containment form is separate from the OCC review process.

17. *Question: Who should I contact if I have problems with my OCC request?*

Answer: eQHealth
Phone: 888-801-9355
Email: co.pr@eqhs.org

Attachment(s):

None

Department Contact:

Cassandra Keller
LTSSOCC@state.co.us