



DMR HCBS Waivers

February 2006

Agenda

- **PRAT Planning and Resource Allocation**
- **HCBS Waivers (New People, Existing People)**
- **Update on Comp Waiver Rates Work Group**
- **Service Options**
- **Individual Budgets, Data, (ISA or Vendor)**
- **Medicaid Billing**
- **Vendor Invoicing to Fiscal Intermediary**
- **Vendor Documentation**
- **Qualified Vendors**
- **FI Responsibilities**
- **Rates**
- **ISA Individual Budgets with start dates prior to 2/1/05**



PRAT
Planning and Resource Allocation

February 2006

Individual Plan

- Every individual receiving supports and services will have a DMR annual IP
- The IP is the foundation for all supports, services, and funding.
- The IP needs to indicate all supports and services within the outcomes and action plan
- The Planning and Support Team (PST) will support the individual in implementing their Individual Plan (IP)

Steps in the Process To Access Services and Supports through DMR



DMR Eligibility

Priority Checklist

Level of Need (LON)

**Planning and Resource Allocation Team
(PRAT)**

HCBS Waiver Eligibility

DMR Eligibility

In order to receive waiver services, individual must be eligible to receive services from DMR.

*To be eligible to receive services from DMR,
a person must:*

- **BE A RESIDENT OF CONNECTICUT, AND**
- **HAVE MENTAL RETARDATION** as defined in Connecticut General Statutes 1-1g,
- **OR HAVE A MEDICAL DIAGNOSIS OF PRADER-WILLI SYNDROME.**

The Priority Checklist

When an individual or family requests services from DMR, the Case Manager will complete a Priority Checklist with the person and/or their family.

The Priority Checklist is used to determine the urgency of the individual's need in relation to others who have requested services from DMR.

The information helps to determine if the individual will be on the Waiting List (want or need services within a year or so), or the Planning List (want or need services in two or more years)

Level of Need (LON)



The LON process helps the department to make equitable decisions in resource allocation.

This information is used to plan ahead for the amount of funds the person may be eligible for when offered an opportunity to apply for a DMR waiver.

The Waiting List Assessment tool is used now to determine a person's Level of Need. A new tool will be introduced next year.

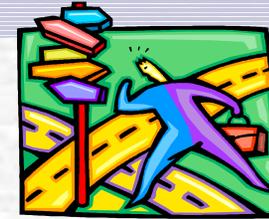
Planning and Resource Allocation Team (PRAT)

The Priority Checklist and the LON Assessment will be sent to the **Planning and Resource Allocation Team (PRAT)** by the individual's case manager.

This information will be used to plan who will be receiving supports and at what amount each year.

The PRAT will review the information and assign a priority to each individual request for services.

Planning and Resource Allocation Team (PRAT)



Priority Ratings

All of the necessary resources may not be available right away so the PRAT will use the information to place the individual on a **Waiting List or Planning List.**

As a result of a federal law suit, DMR and the ARC of CT have a "Settlement Agreement" that specifies that 150 people each year will receive residential supports based on a Priority System that determines urgency of need.

The same process is used when people request day or vocational services.

Planning and Resource Allocation Team (PRAT)

Enrollment in the Waivers

DMR has to award funding to someone before it can offer an opportunity to apply for one of the DMR waivers. The funding comes from the resources allocated to implement the Settlement Agreement, from money provided to someone else who no longer needs it, or from the Graduate or Age Out funding allocated by the Legislature each year.

If the resources assigned to the person are expected to meet their projected needs for supports, they will be asked to enroll in one of the DMR HCBS Waivers. If they do not want to be enrolled in a waiver, the individual will not be able to get the services and/or funding set aside for them.

Planning and Resource Allocation Team (PRAT)

Requests for Additional Funding

The resource allocation planned for the individual can be adjusted based upon additional factors not reflected by the LON process.

Requests for services with costs exceeding funding ranges are reviewed by the PRAT, and sent on to regional and statewide Utilization Review Committees, if needed.

Requests in amounts higher than the identified funding ranges are only approved to address health and safety needs.

HCBS Waiver Eligibility



If an individual is eligible to apply for one of the HCBS Waivers, *DMR will assist them through the application process.*

Being enrolled in one of the waivers will help the person create their own package of services that is right for them.

HCBS Waiver Eligibility

To be eligible for either of the waivers, you must:

- ✓ Already be eligible for Medicaid, or be determined to qualify for Medicaid.
- ✓ Have income and assets no greater than the guidelines set by the Department of Social Services (DSS).
- ✓ Have needs that can be met through a waiver so that you do not have to live in an institution (ICF/MR) or Nursing Home to have your support needs met.
- ✓ Need waiver supports in addition to the supports that you already have to lead a safe and healthy life in the community.

These other supports can include DMR state-funded services, Medicaid state plan services, community/generic services, and natural supports such as family or friends.

Utilization Management-

- Comprehensive Supports waiver requires prior approval to exceed funding limits. Includes group home placement in excess of \$90,000.
- Examples of reasons to approve would be significant behavioral, medical or physical support needs requiring additional levels of support for health and safety; absence of natural supports; no caregiver necessitating a group home placement for someone with Minimum LON.
- Waiver IS NOT intended to provide paid 24 hour supports for 1 person living arrangements unless it is within the funding limits, or, is required due to extreme behavioral, mental health concerns that present a risk to others.

Request for Additional Services

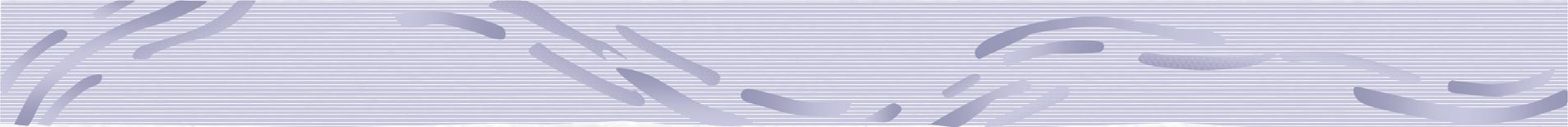
- Any time an individual requests additional services covered under a waiver, amend the plan as needed regarding needs and/or preferences, and as an Action Plan indicate that the CM will submit a Request for Services to PRAT
- The Request for Services and a LON to PRAT initiates the review.
- If denied, notice copied to CM. CM needs to re-visit the plan in cases where an alternative action may be needed, for example the person wanted to live in an apartment by themselves or desired a 1:1 long-term day support, but would consider different arrangements if request was denied.

Update on DSS Appeals

- PRAT reviews, Case Management Supervisors need to emphasize need for the request packets to be complete and up to date.
- CM copied on denial notice, CM should f/u with individual/family to be know if the individual/family would like to discuss alternatives rather than appeal.
- If appeal goes forward, individual consumer has a right to be present and should be unless extenuating circumstances
- Indiv/Family will be requested to go to nearest DSS office, DMR staff should be present to assist indiv/family in locating the room.
- CO staff will represent the department in appeals initially – hearings are by video conferencing
- Content and format for how information should be presented and desired supporting documents will be forthcoming.

Funding Limits by Level of Need

<u>Service Package</u>	<u>Minimum</u>	<u>Moderate</u>	<u>Comprehensive</u>
<u>Res/Home and Community Supports</u>	up to \$30,000	up to \$60,000	up to \$90,000
<u>Day and Vocational Supports</u>	up to \$19,500	up to \$24,000	up to \$35,000
<u>Home and Vehicle Modifications</u>	All LON Categories up to \$10,000 for each service in a three year period		



The Individual and Family Support Waiver

is designed to support individuals who live in their own homes or in their family homes and receive less extensive supports that typically cost less than \$52,000.

The Comprehensive Waiver

is used to provide services to individuals who live in licensed Community Living Arrangements (CLA), Community Training Homes (CTH) or in Assisted Living Facilities.

It can also be used to provide services to individuals who live in their own homes or in their family homes and who are in need of a comprehensive level of supports, usually as a result of significant physical, behavioral or medical support needs

October 1, 2005.....

- Old DMR waiver expired, each person enrolled into either the IFS waiver or the Comprehensive waiver
- Comprehensive- all CLA and CTH, Public SL, and all others with a service package in excess of \$52,000 = 4,059
(Waiver CAP is 4900)
- IFS = 2,558 (Waiver CAP 3115)

COMPREHENSIVE SUPPORTS WAIVER-Eligibility

- DMR eligible and meets Level of Care
- Medicaid eligible (SO 5 included)
- Lives in or will live in a licensed setting (CLA, CTH or Assisted Living)
- Lives in own or family home and needs more paid waiver supports than the IFS waiver allows

PA 05-280 Section 31

Public Act 05-280 section 31 requires:

- any person seeking or receiving services eligible for Federal reimbursement must enroll in the DMR Medicaid Waiver program if eligible, in order to continue to receive services or to remain eligible for new placement or services.
- Any person who is not eligible for the Medicaid program due to excess income or assets may remain in their existing program if they have an agreed upon plan with the Department to spend down excess income or assets so that the person qualifies for the Medicaid program.

PA 05-280 Section 31

- Consumers must be enrolled in one of the HCBS Waivers or have an approved asset reduction plan before starting any services funded by DMR.
- A plan to reduce assets, which may include privately paying for programming, is required.
 - The plan will be reviewed and approved by PRAT. PRAT will identify when the plan will transition to DMR payment.
 - The individual or family, when part of the asset reduction plan, will make required payments to an FI.
 - The FI will pay the providers.

Comprehensive Waiver Services

Residential/Home and Community Supports

Residential Hab¹

Assisted Living¹

Supported Living

Personal Support

Adult Companion

Respite

Transportation

Consultative Services

Interpreter

Medical Equipment and Supplies

PERS

Family and Individual Consultation and Support³

Individual Directed Goods and Services

Day and Vocational Supports

Group Day Supports

Supported Employment

Individualized Day Support

Transportation

Consultative Services

Interpreter

Medical Equipment and Supplies

Family and Individual Consultation and Support³

Individual Directed Goods and Services

Other Services

Home Mods²

Vehicle Modifications²

¹Res Habilitation and Assisted Living may not be utilized at the same time, or separately in combination with Personal Support, Adult Companion, and Respite services.

² Can be authorized as separate service costs above the Residential and Day/Vocational Package funding level limits, see also service definition limitations.

³ May be authorized as a separate service cost above the Residential and Day/Vocational Package funding limits when needed to assure the health and welfare of a self-directed participant

Individual Directed Goods and Services

Services, equipment or supplies that will provide direct benefit to the individual and support specific outcomes in their IP

- Reduce the reliance on other paid supports
- Directly related to the health and/or safety in home
- Be habilitative in nature
- Contribute to a therapeutic goal
- Enhance person's ability to integrate into their community
- Provide resources to expand self advocacy skills and knowledge
- Person has no other funds to purchase the described goods or services

Individual Plan

- Every individual receiving supports and services will have a DMR annual IP
- The IP is the foundation for all supports, services, and funding.
- The IP needs to indicate all supports and services within the outcomes and action plan
- The Planning and Support Team (PST) will support the individual in implementing their Individual Plan (IP)

People in Services

- ☛ At the next plan meeting, inform person of new waiver options.
- ☛ If people want to take advantage of new options, use the portability procedures to get an Individual Budget limit
- ☛ Individual Budget should not exceed the established funding ranges by LON
- ☛ When possible, Individual Budgets should be permitted to go up to established funding ranges by LON

Those New to Services

- Which waiver an individual makes application to may need to be decided “after” the individual planning in cases where it is unclear if a budget package will exceed \$52,000.
- Established waiver rates will apply in all cases except CLA and complex day services.
- New service packages, except CLA, CTH, and complex day programs will be provided through an Individual Budget by qualified providers and paid through an FI.

Comprehensive Waiver Workgroup Update

CLA Rates: Uniform rates under development. Target date is July 1, 2006

Group Day Programs : Establish a day rate for each program model based on provider contracts using a standard attendance rate.

SLA and Individual Placement Programs - Establish an hourly rate.

Identify provider (s) to pilot attendance based reimbursement system.

Track Attendance and the effect on payment.

Begin Rate Based system for SLA and IP programs.

Start Rate based system for all day programs using one rate for each program model.

Incorporate Level of Need determinations with each participants individual budget. Track attendance for each individual client based on identified individual budgets.

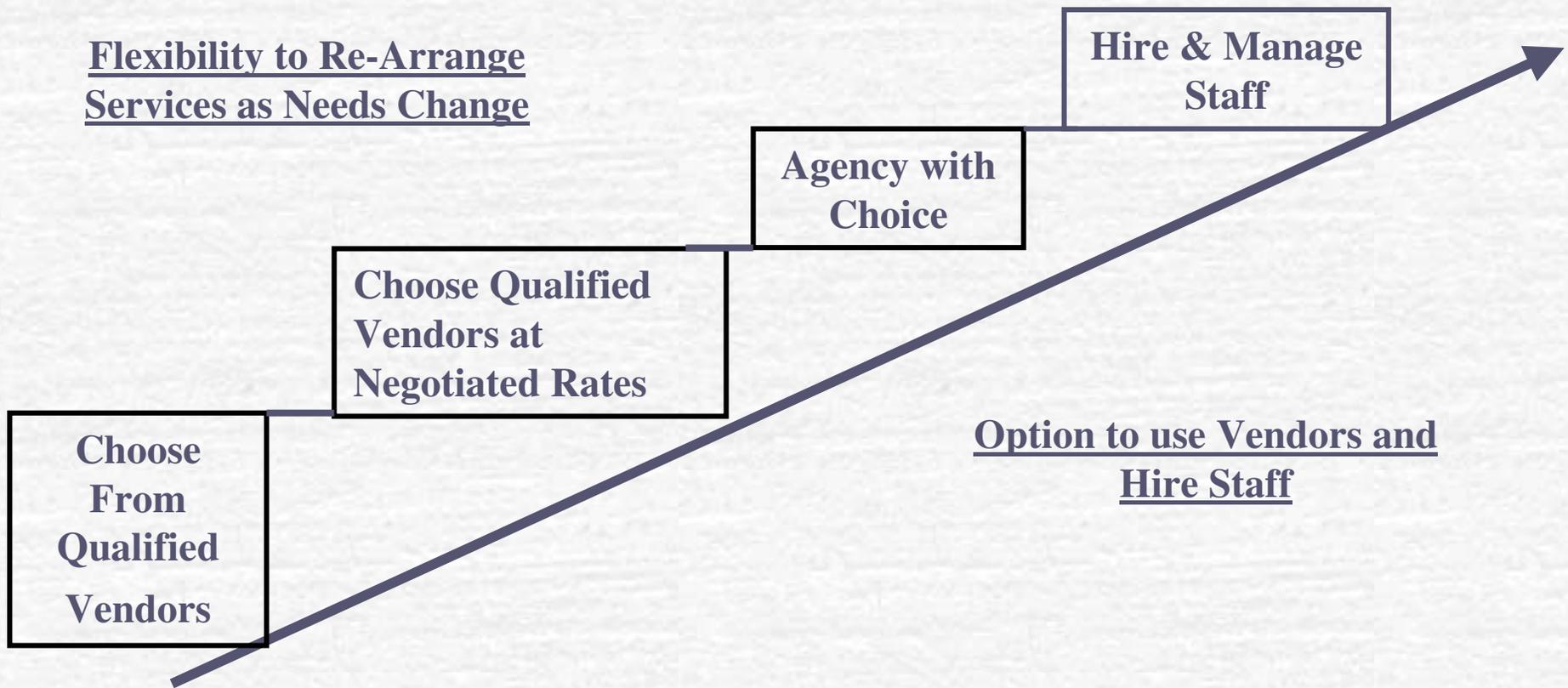
Negotiate redistribution of resources to match LON within current allocation. Outliers to be identified and placed in a separate category.

Begin Individualized Rate system.

Moving to uniformed Rates Some providers may be able to move to the rate system with little or no additional cost. Indexing of any future COLA's?

Service Options

The two DMR Waivers provides Individuals and Families with a broad range of Self Directed Service options.

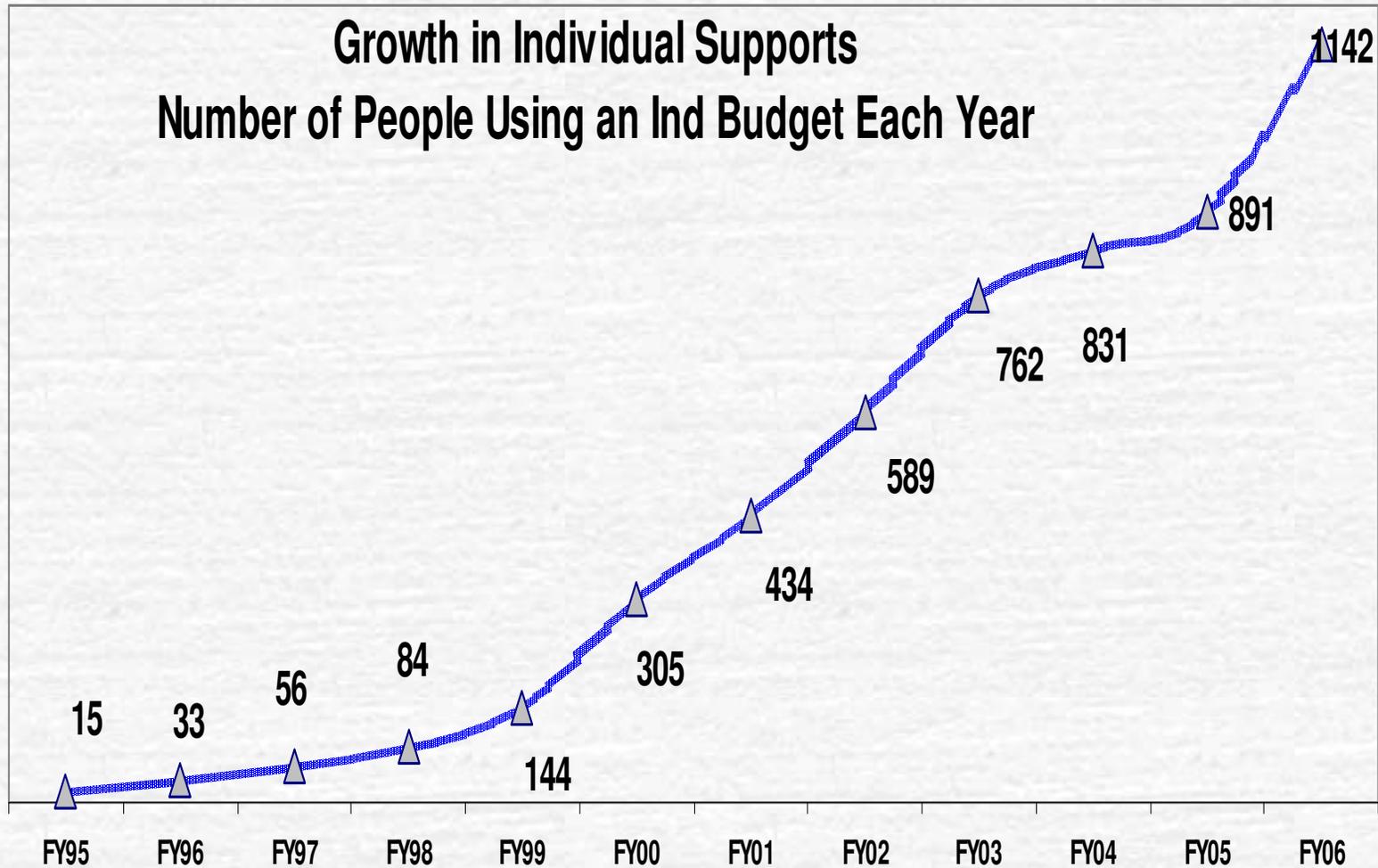


Individual Budgets

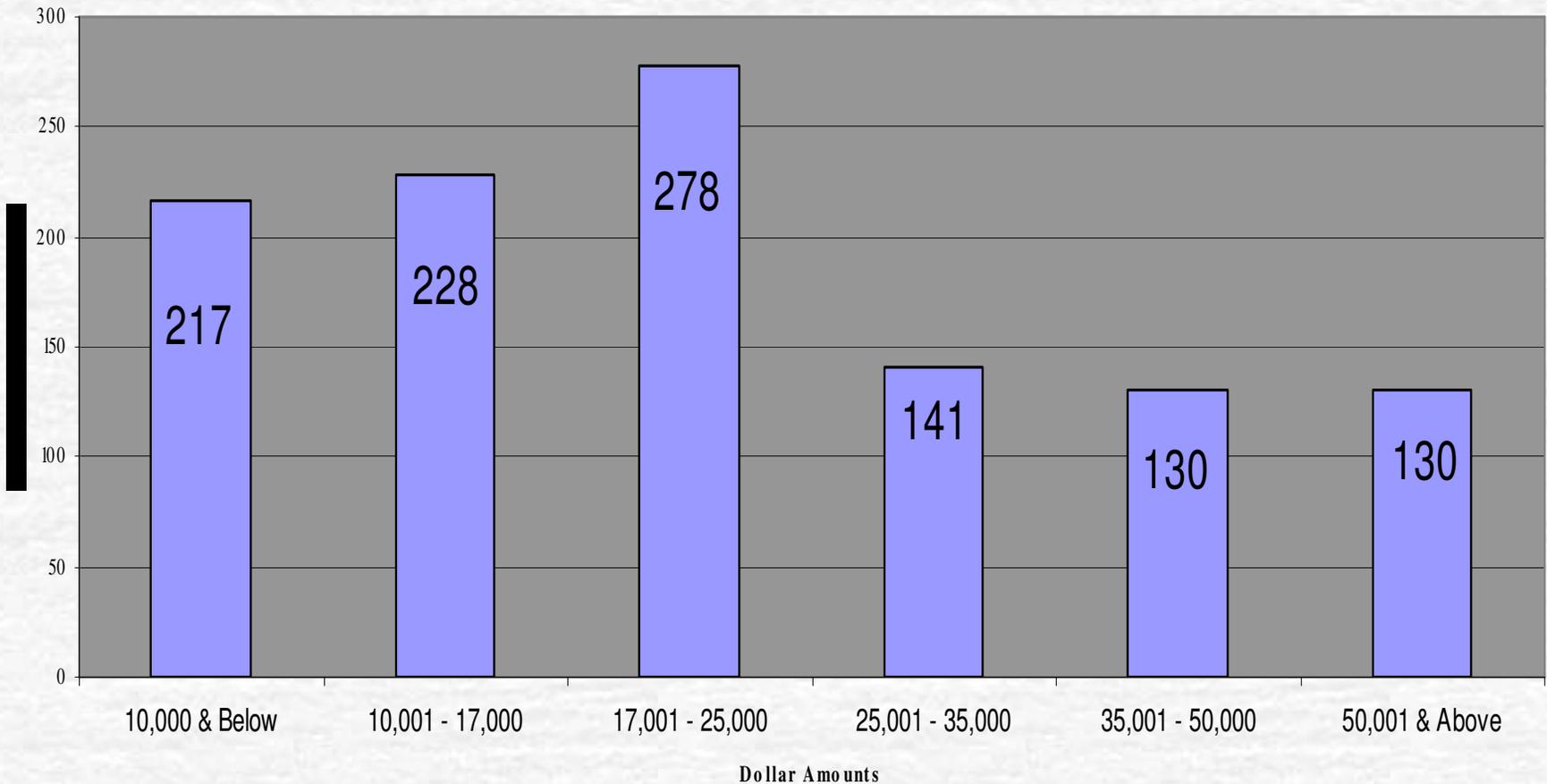
- ❑ **ISA Individual Budgets: Individuals who hire their own staff or have a negotiated service rate.**
- ❑ **IFS or COMP Waiver Individual Budgets: Individual who use qualified vendors at established rates for all of their services.**
- ❑ **DMR will use one budget format for all Individual Budgets beginning January 1, 2006**

Growth in Individual Supports

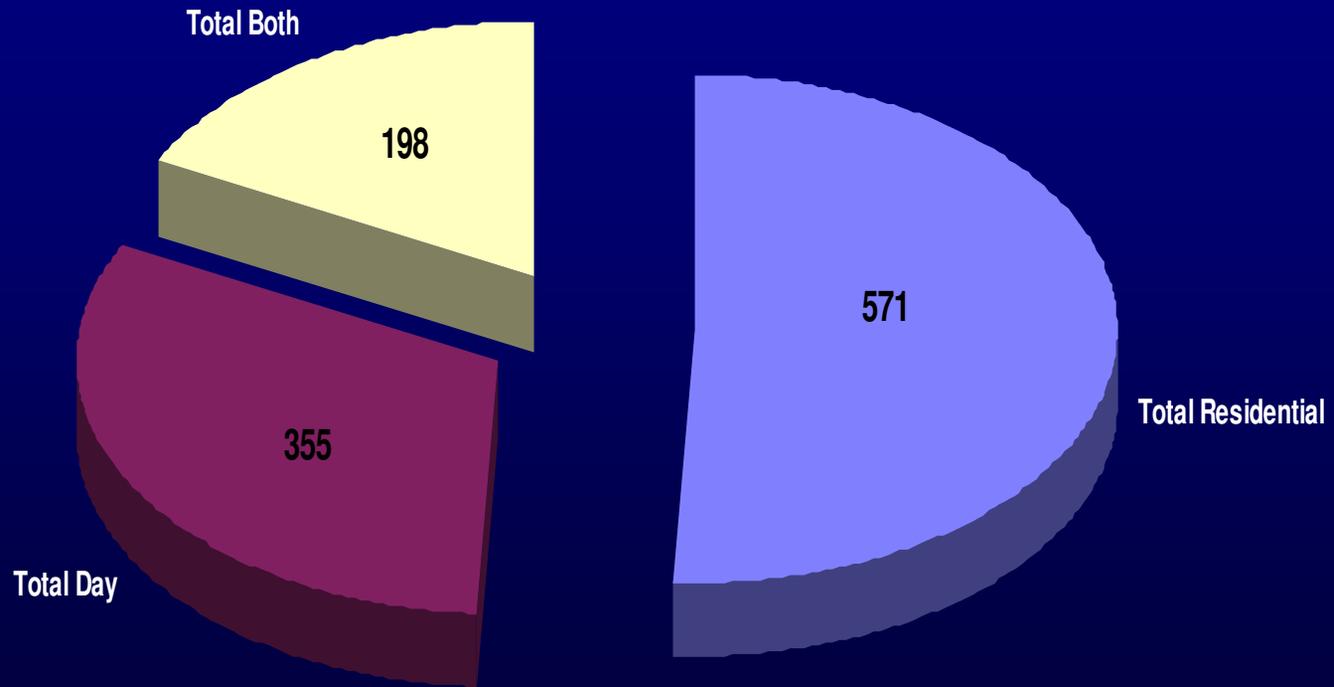
Number of People Using an Ind Budget Each Year



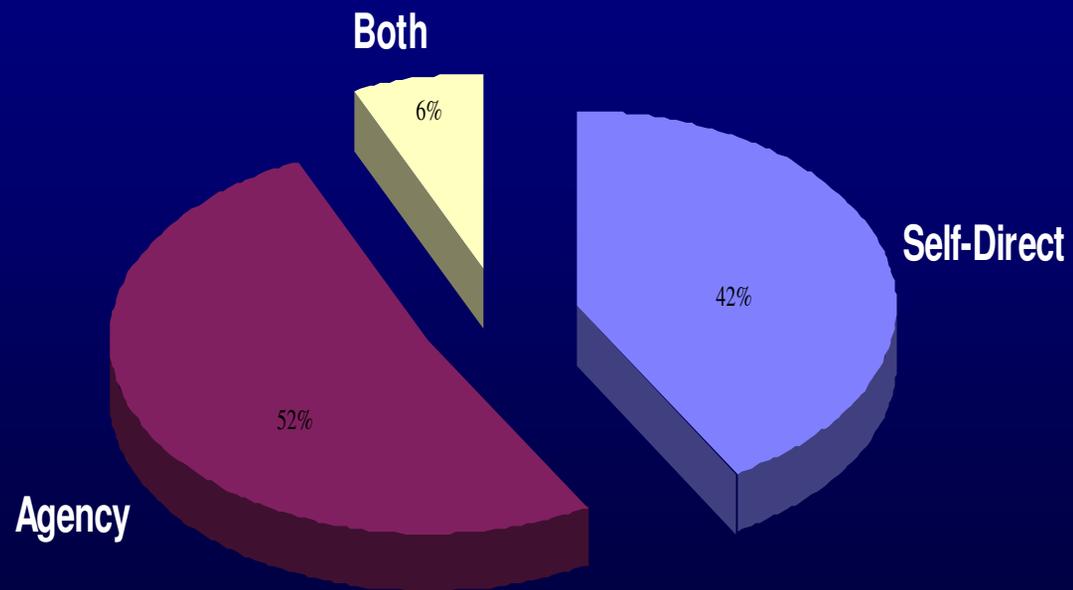
Total Regional Funding



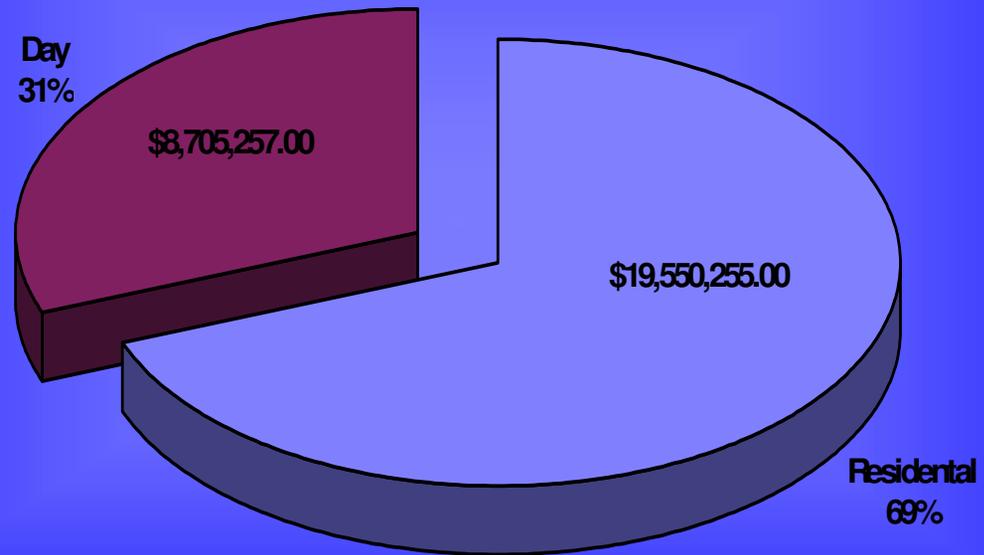
Individual Budgets by Service Type



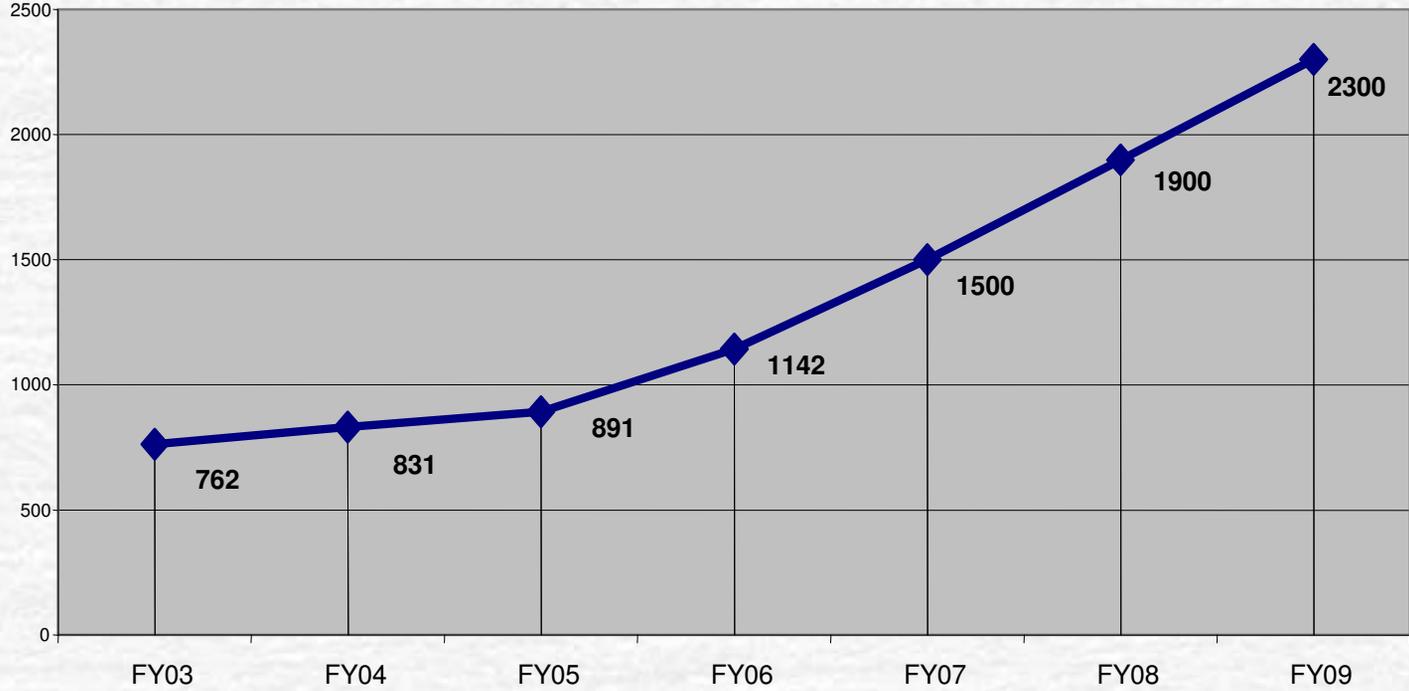
Individual Budgets by Porvider



Funding by Support Type



Individual Budget Projected Growth by Fiscal Year



**799 Individuals Have an Individual Budget
AND
Are Enrolled In The Waiver Program As Of November 9, 2005**

WAIVER TYPE	North Region	South Region	West Region	TOTALS
Comprehensive Waiver	56	79	63	198
IFS Waiver	137	239	225	601
Total Of DMR	193	318	288	799

**As of November 9, 2005 There Are 1,124 Individuals Who Have Individual Budgets
71% Of The People With An Individual Budget are Enrolled In The Waiver**

Medicaid Billing

□ Contracts

- Provider submits monthly attendance to DMR (If person with Ind Budget shows up on DMR attendance form – write in ISA/Individual Budget)
- DMR reviews against CAMRIS data and submits to DAS
- DAS bills Medicaid on a per diem basis with individual rates for each provider by service type. Each provider has a T-19 provider performing number.

□ Individual Budgets

- Provider submits invoice to FI for each individual with services provided by date and number of units.
- FI submits electronic file with required data fields to DMR and DAS. Required data fields include date, type, and number of billable units of service.
- Regions are the performing provider and billing rates are uniformed.

Provider Invoicing to FI

- ✓ Vendor uses monthly or bi monthly billing cycle.
- ✓ Invoice submitted to FI by vendor for each individual that includes all services provided by date and number of units.
- ✓ FI makes payment within five days of receipt of invoice unless there is a billing discrepancy:
 - Bi monthly bills that overlap dates and services- double billing
 - Billing rate/amount is different than rate in authorized Individual Budget
 - Bill is sent with date ranges
 - Delayed invoices or several months put into one invoice (rolling budget periods)
 - Two services billed at the same time
 - Invoice is for a service that is not in the budget.
 - FI does not have authorized budget from Region
 - Program payment from region not received by FI

Vendor Documentation of Services

Group Day Services: Maintain service note documentation signed by responsible employee and dated for each day services were provided. If the individual arrives more than one hour after the usual start time or leaves more than one hour before the usual end time, the actual amount of time the individual is in service is recorded. The Group Day provider will maintain service records related to the acquisition of outcomes/goals/objectives, provided to the person.

Intensive Staffing: Document the date, number of units/hours provided, and support type (feeding, behavior, medical) for each day the individual received the service, and signed by the responsible employee.

Supported Employment/Individualized Day

Documentation includes date of service, number of units/hours provided, a description of the activities related to outcomes/goals/objectives provided to the person, and a signature of the employee providing the service.

Vendor Documentation of Services

□ IS Habilitation, Personal Support, Companion : The employee providing the service, records the date of service, start and end time, and the tasks performed. The employee signs and dates the log to certify that he/she worked the time and dates listed and performed the indicated tasks. The person /responsible party must sign to certify that the tasks were performed and the time is correct.

□ Transportation Document the date service is provided, the purpose, and number of units, (mileage or trips when applicable) and a signature of a representative from the Vendor.

□ Consultative Services Progress notes with a description of the activities related to outcomes/goals/objectives as described in the Individual Plan signed by the individual providing the service that include the service type, date of the service, the number of units/hours provided.

Qualified Vendors

- Bills only for services that are actually provided at or below established rates.
- Submits billing documents after service is provided and within 90 days
- Accepts payment from DMR as payment in full
- Retains financial and statistical records for six years from date of service provision
- Signs a provider agreement with the Medicaid Agency (DSS).

Non Qualified Vendors

- There are few agencies who have been providing individual supports and are not qualified.
- Case managers and brokers will assist the individual or family with finding a qualified vendor before March 1, 2006
- The last billing month for non qualified vendors is February 2006.

Self Directed Agreement

- ✓ Funds received under this agreement can only be used for items, goods, supports, or services identified in the service recipient's individual plan and authorized individual budget
- ✓ To actively participate in the selection and ongoing monitoring of supports and service
- ✓ To enter into an agreement with the provider agency/agencies or individual support worker(s) I hire. The agreement is outlined in the Individual Family Agreements with Vendors and Employees and identifies the type and amount of supports and services that will be provided
- ✓ To review the fiscal intermediary expenditures reports made under this agreement
- ✓ To get prior authorization from the DMR if I intend to purchase supports, services, or goods from a party that is related to me through family, marriage, or business association
- ✓ To participate in the department's quality review process.
- ✓ To use qualified vendors enrolled by DMR.
- ✓ To follow training and qualification requirements for individuals that I hire and to submit documentation to the Fiscal Intermediary to verify that the staff I hire meet the training and qualification requirements
- ✓ I acknowledge that the authorization and payment for services which are not actually rendered could subject me to fraud charges under state and/or federal law

Vendor and Self Directed Staff Qualifications

Whether an individual chooses an agency vendor, an agency with choice, hire your own staff, or a combination of above, any individual providing waiver services must meet established waiver service qualifications.

FI Responsibilities

❑ Enrollment Meeting with families who self direct their services:

- ✓ Share DMR information: Cost guidelines, Fact Sheets
- ✓ Prior to start of services: Employee Application, CHBC, Registry, License, other certifications if required, Medicaid Provider Agreement,
- ✓ Vendor Agreement and Employee Agreements: Confirms service type, vendor or provider name, rate and frequency of service.
- ✓ Within 30 days: Training Verification and documentation form.
- ✓ Signed time sheet by employee and employer verifying services were provided.

FI Budget Management

- Pays for goods and services up to monthly allocation in authorized budgets.
- Can pay over monthly amount for a service if there is a carry over balance. Notifies CM.
- Assists case managers with documentation to move resources within the budget to existing or new services when needed.
- Maintains list of employees interested in working for individuals and families
- Sends a monthly and quarterly expenditure report to individual and case manager.
- Responsible for all documentation and records for each individual and their employees.

ISA Individual Budgets

- ❑ Some ISA individual budgets that started prior to February 1, 2005 and use a qualified vendor have budgets with a monthly amount.**
- ❑ All ISA and Individual budgets that are managed by a Fiscal Intermediary will be required to provide services and bill for services on a unit basis on or before July 1, 2006.**
- ❑ The hourly rates can be based on the current cost of the service but services may have to be billed separately in they are currently bundled.**

Rates

- **Rate Adjustment Retroactive to July 1, 2005**
 - **Includes 4% COLA**
 - **Group day includes Utilization Change from 95 to 90 %.**

- **New Rates: GSE – B and SHE – B** These rates are for GSE and SHE programs that provide the individual a paid leave.

Rates- Retroactive Payments- IFS Ind Budgets

- Fiscal Intermediaries are recalculating these budgets with the adjusted rates, which means that case managers and brokers will not have to complete any paper work.
- The FI's will provide each region with the revised budget amounts for each individual. The fiscal office will issue a payment for the additional costs associated with the COLA and rate adjustment to the FI.
- Vendors can bill using the adjusted rates for November services. The FI's will pay the retro active increase due the provider for services provided through October 31, 2005 in December.

Rates- Retroactive Payments- ISA Ind Budgets

- **Simplification of Budget Revisions**
- **ISA individual budgets that started on or after February 1, 2005 with IFS vendor services should have the adjusted rates applied unless the family wants to negotiate with the vendor. Increases will be retroactive to July 1, 2005.**
- **ISA individual budgets initiated prior to February 1, 2005 with vendors for day and residential services that are not using waiver rates should also be considered for the COLA, however, families may want to negotiate with the vendor.**
- **FI will work with the Vendors on the retroactive payment and billing with revised rates once the region has sent them an authorization.**