Following is an Informational Notice from the Division of Disability, Aging, and Rehabilitative Services

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TO: DD, Support Services & Autism Waiver Case Managers and Providers

BDDS District Offices & BDDS Staff

FROM: David Gootee, DDRS Assistant Director

RE: Annual Plan Clarifications

DATE: October 28, 2005

Hello to all,

The Provider, Case Manager and family meetings have now been held around the State. We have received many phone and e-mail messages with questions, concerns and fears about what will happen as we implement the Annual Plan. This letter is to clarify our position on the most common issues raised. We recognize this letter contains a lot of information and ask that you take the time to read it thoroughly and distribute as appropriate. During this time of change, it is important to verify any information you hear from non-state sources with actual bulletins, announcements and information provided by DDRS. If there are questions about the annual plan process that are not addressed in these formats, please send those questions to BDDShelp@fssa.in.gov. Thank you for your continued cooperation.

Individual Support Plans and Service Changes

The Annual Plan is designed to encourage and promote maximum flexibility and choice in the provision of services, given the limited financial resources available. Individual Support Teams have both the challenge and the opportunity to design plans of care that meet the needs of individuals without having to confine activities to the structured requirements of the old service definitions. The Individual Support Plan (ISP) is the guiding document for all issues related to an individual's service. In addition to meeting the health and welfare needs of the individual, services must be delivered in a manner that assures an individual's progress toward the outcomes described in the ISP.

The most common things we are hearing are "my provider (or case manager) said my hours have been cut" or "my travel is gone." The new billing system designates an amount of money to provide for the needs of an individual over the course of a year. There are many ways to fulfill those needs. Using the old model with its constraints, restrictions and frustrations (i.e. tying a dollar amount to a quarter-hour unit of staff time) as a basis is not only inappropriate, it is wrong. It is overly simplistic to say that "your services are cut" when, in fact, services are changing and may be provided in a different manner. With the increased flexibility being provided, all parties

should be prepared to explore the need to share staff, utilize sleep shift personnel or technological supports where appropriate. There are also opportunities for increased use of volunteer services and for family support. The increased flexibility of a daily rate will allow families to be more involved in a loved ones life, with no fiscal impact on the provider.

A subtle, but important, issue is the point of reference used when discussing these billing changes with families. The historical reference point, used by all of us, has been the budget which indicates the maximum allowable amount of service available to any one waiver participant displayed in units and hours. Only in the rarest of cases was the actual service delivered close to the amount approved. Actual paid claims data for the DD waiver ranged from about 80% for RHS and Case Management to 60% for Behavior Management to less than 50% for Day Services.

The new annual funding allotments are based on actual spending history, which is a more realistic measure of the amount of state funding needed to provide for an individual and help them achieve their goals. Given this, it is unrealistic to speak to families and individuals in terms of a large percentage cut from a “budget” that included service amounts that have not been delivered.

Unilateral decisions about service provision restrict the creative abilities of the Individual Support Team to design a plan of care that recognizes the realities of everyday life, including the limited financial resources available from the State, to maximize the ability of the individual to achieve their outcomes. The Individual Support Team, and not any one member, must drive decisions related to change in service. However, neither should any single individual of the team unilaterally refuse to agree to changes in the plan. In those cases when the Individual Support Team cannot agree upon the types or amounts of service needed to meet the needs of the individual, the dispute resolution process, as described in 460 IAC 6-10-8, is an option available through the BDDS District Office.

The Service Planner

In the past, the Service Planner was used to calculate the number of quarter-hour units and the dollar amount for a specific service. The information on the Service Planner contained the specific type of service (CHPI, CHPG, RHS1, etc) and the specific staff ratio. As of November 1, 2005, the Service Planner will serve a new roll that is not tied to dollar amounts for a service, or to a specific prescribed staff ratio.

The Service Planner will continue to be filled out by the Case Manager, but will only indicate a general category of service (i.e. RHSA or DSRV). As before, time with family, school and other non-paid supports can be included in the Service Planner. The Service Planner is to visually reflect a typical week for the individual. As Teams meet to determine changes to service as a result of the annual plan project, the Service Planner should be updated to reflect those changes.

The Service Planner will be clearly indicated as not to be used for audit purposes and is meant to be a guide and should not be interpreted as an expectation for service delivery for each and every day.

When concerns about the amount of service provided are brought to the State, we will look first to assure that the health and welfare needs of the individual are met, and then to the Individual Support Plan and the required monthly summaries to see how the individual is progressing toward outcomes. The Service Planner will not be used to measure provider performance.

As always, concerns around the health and welfare of an individual or whether or not they are progressing toward outcomes, must be documented through the incident reporting or complaint process through the Bureau of Quality Improvement Systems.

Implementation of the Provider Selection Policy
The Provider Selection Policy distributed on October 6, 2005 became effective immediately upon release. This policy has raised many questions and concerns as provider changes take time to arrange and implement. In recognition of these concerns, we are rescinding the policy of October 6, 2005. We will develop a similar policy to become effective for individuals as they go through their annual ISP review process after July 1, 2006.

Case Managers may continue to submit Vendor Change Updates for all services as they do today.

Rate Reviews
Attached is the Annual Plan Rate Change Request Form that was distributed with the October 1, 2005 list of rates for waiver participants. Please use this form to alert the State to rates that may need to be need reviewed due problems with billing during the 2005 fiscal year. To expedite these requests, submit the relevant documentation with the form. Requests related to budget amounts or services previously denied on a CCB will not be revisited through this process. The State has begun reviewing forms submitted and will send confirmation of receipt as forms are received.

The State will accept these forms from providers through November 30, 2005 as part of the initial conversion process. The State is prioritizing these requests and plans to have all requests reviewed and appropriately addressed by December 31, 2005. Please note that rate adjustments made after November 1, 2005 will be made retroactive to November 1, 2005. The Rate Change Request form can be e-mailed to Annualplanhelp@fssa.in.gov or faxed to (317) 234-2099.

$.02 and $.03 Daily Rates
Rates of $ .02 or $.03 cents per day are “marker” rates. The individual with these rates had no paid claim history for the entire 2005 fiscal year for a service. These rates were used by the State as a marker to hold the service on the new Annual Plan CCB. If you have not done so already, providers with these rates need to fill out the attached rate review form and return it to the State. Upon receipt of the form verifying that the individual is receiving the service, the State will generate a new rate and reissue the Notice of Action.

The form can be e-mailed to Annualplanhelp@fssa.in.gov or faxed to (317) 234-2099.

Banked and Borrowed Units
Case Managers do not need to submit Update CCBs for dates before October 31, 2005 to move banked or borrowed units for Case Management or Behavior Management. For units borrowed from November 1, 2005 and after, the Case Manager or Behavioral Management provider will only need to demonstrate that the number of utilized quarter-hour units did not exceed the total on the original, pre-annual plan conversion Notice of Action.

The automatically created annual plan NOAs, reflect only the number of units for November 1, 2005 through the end date of the plan for Respite and therapies (Speech, Occupational, Physical, Music, Recreational and general Therapy services). However, this does not impact banked or borrowed units from the pre-conversion NOA. The prior authorization at EDS will reflect the total amount of units available for the year so banking and borrowing can continue as planned.

Update CCBs submitted for dates up to and including October 31, 2005 submitted for any reason must include the actual number of Case Management, Behavior Management and Respite and Therapy units provided. Otherwise, the system created to handle banked and borrowed units will be overridden and claims will be denied. If this occurs, or if claims for banked or borrowed units are denied at any time during the life of the plan of care that covers October 31 and November 1, 2005 please notify the INsite Help Desk at INsitehelp@fssa.in.gov.

Title XX and Day Services
Those providers of Title XX services and Waiver Day Services need to continue to document and bill Title XX for hours in which the individual earns more than 50% of minimum wage. However, for Waiver Day Services, the provider will bill the same amount each day regardless of the amount the individual is paid.

Monthly Documentation
We recognize that most Day Service providers do not have QMRPs on staff. For Day Service providers, the required signature for the Waiver Participant Status Form can be done by the day program supervisor if a QMRP is not on staff.

While we encourage providers to use the forms for Attendance and Participant Status provided by the State, we don’t want to complicate the documentation process unnecessarily be requiring use of the specific form if the provider has something that contains the same information already in place. Therefore, if a provider has forms that include the same information in a similar format, those forms can be used in place of those provided by the State. Those providers that use electronic data gathering systems may continue to use those programs. All information included on the State forms must be included in any electronic system or provider generated paper form and must be easily recognized as a comparable form for audit purposes.

In those situations where agreements to provide services are worked out between providers, the State expects the provider that is billing EDS directly to maintain all of the Attendance and monthly Waiver Participant Status forms for the individual. That provider will need to collect the Attendance Forms and monthly Waiver Participant Status forms from all providers with which they are working. The Attendance

record is to indicate days the individual is in service, with either the direct billing provider or any provider they are working with, it does not need to be marked and initialed for days the individual is not in service at all. The provider bills the daily amount for all 365 days of the year, but the attendance form needs to reflect the days the individual is actually in service.

The monthly Waiver Participant Status form should be provided to the individual's Case Manager. This will assist the Case Manager in compiling their 90-day reports and will help keep members of the Individual Support Team informed of the individual's progress. Providers are still required to participate in the 90-day review process.

Opportunity

We understand that the approach we are initiating is a major change in philosophy and methodology to serving individuals on the DD, Autism and Support Services waivers. The intent of these changes is to respond to 3 years of mounting complaints that the current system was broken, suffocating any hope of true choice by a consumer to live other than a "budgeted" life. Change is always tough and a major change generates anxious moments for all. I know that if we can stay focused on how to use what is available in creative ways, we can assure the outcomes that matter for those we serve.

Sincerely,

Dave Gootee, Deputy Director
Division of Disability and Rehabilitative Services