DDS EXECUTIVE BRIEFS
An Update on CT DDS Initiatives

January 23, 2008 Issue 21

Status of HCBS Waiver Renewals

The IFS Waiver renewal application has been submitted to CMS and we have addressed all of their comments and questions. We anticipate approval of the waiver no later than January 31. As stated in an earlier edition of Executive Briefs this renewal application was submitted with no substantive changes to the existing IFS waiver. Once CMS has approved this renewal, DDS will submit amendments to both the IFS and the Comprehensive Waivers. The amendments will include some new services such as Live-in Companion and Health Care Coordination as well as aligning services and processes in the two waivers. We anticipate having the draft amendment applications complete by the end of February. Below is an outline of the steps in the process for reviews and approvals.

1. Submission to DSS for fiscal and programmatic review.
2. DSS forwards to OPM for review.
3. Once OPM approval is received, DSS posts in the Law Journal and allows 15 days for public comment. The law journal is published twice a month.
4. The waiver application/amendment is revised if needed after public comment and is sent to the legislature for approval. The legislature has 30 days to approve, reject or require modification of the application/amendment. Prior to issuing a decision the legislature is required to hold a public hearing on the application.
5. If approved, the application will be sent to CMS for their review and approval. CMS requires 90-180 days for review and approval.

We will notify all providers once the amendments are to be published in the Law Journal so they can take advantage of the comment period.

For comments or questions, please contact Debbie Duval at 860-418-6149 or deborah.duval@ct.gov.

Update on Proposed New Day Rate Structure

In cooperation with the Waiver Workgroup, the Department continues to work on developing a revised Fee for Service rate structure for day services. The new rate structure would eliminate the staffing modifier and would substitute multiple rates that are based on the individual's level of need (LON). The LON composite day score would determine the rate of reimbursement the day provider would receive for the supports provided to the individual. These changes are

being made to address the concerns of providers identified by the Waiver Workgroup. These included a lack of clarity in determining whether a staffing modifier is needed, how to calculate the amount of hours a staffing modifier is needed, the inadvertent disincentive for an individual to participate in supported employment due to the lower reimbursement rate and the complexity of billing on an hourly basis for group settings.

Draft rates for group day programs based on the new rate structure were distributed over the summer. In a letter dated September 19, 2007, the Department asked all providers of day programs to complete an analysis of the effect the new rates would have on their programs. To date, 30 of the 103 day providers have submitted the analysis. Thanks to their efforts, the Waiver Workgroup has been able to identify issues with the proposed rate structure. The main issue centers around the LON score and the rate classification. Revisions to the proposed rate structure are currently underway. The analysis completed by providers has proven to be invaluable in the effort to develop a fair and equitable rate and is much appreciated. However, the Department and the Waiver Workgroup encourage all those providers who have yet to complete the analysis to do so as soon as possible. This information is critical to the Department to understand all the various nuances in the system. Even more important, providers should complete the analysis to better understand the effects a Fee for Service system will have on their particular agency and begin the preparation towards its eventual statewide implementation.

Any provider who has not received the forms for the rate analysis or the day program LON scores should contact Peter Mason at 860-418-6077 or peter.mason@ct.gov.

Quality Service Review (QSR) Update

QSR Data Application Training

We are making progress toward deployment of the QSR Data Application. The DDS Information Technology and Quality Management Divisions are actively testing the system and responding with solutions to a few remaining technical problems. As soon as this testing process is complete and we are confident that the system is working effectively, we will notify providers of the new timeline for deployment and application training. We appreciate your continued patience.

Please contact Charlan Corlies, DDS Director of Quality Improvement Services at char.corlies@ct.gov or 418.6133 if you have questions regarding the QSR Data Application.

QSR Provider Certification Reviews

Central Office Quality Management Services will initiate reviews for non-licensed services using the QSR tools in April 2008. Reviews will be conducted for a sample of individuals who receive non-licensed services such as Individual Supports (formerly known as Supported Living), Day Services, and Self-Directed Services. QSR review team members will meet with providers before and after the review to discuss the review process and to share their findings. Until the QSR Data Application is successfully deployed, the central office provider review will not result in certification. However, central office review findings will be included in the regional provider annual report. Once the data application is deployed, we will begin using review findings for certification purposes.

DDS continues to work on revisions to the current CLA and CTH regulations. Our goal is to smoothly integrate regulation within the new DDS QSR by Fall 2008. Until that time, CLA and CTH licensing reviews will continue under current regulations. Periodic updates on progress toward regulation changes will be shared with DDS staff and providers.

Please contact Dan Micari, DDS Director of Quality Management Services at Daniel.Micari@ct.gov or 418.6081 if you have questions regarding QSR Provider Certification Reviews.

Provider Profiles

The Department is working with the Provider Council on a proposal to post information from QSR reviews to the DDS website beginning in September 2008. An interim plan for the profiles will be developed while we work to successfully deploy the QSR Data Application. The profiles will be very helpful to individuals and families seeking information about the quality of provider services and supports. Over the next couple of months, we will gather information from individuals, family members, and providers about the type of information they would like included in a provider profile. Please contact your regional Quality Improvement Director if you have suggestions for the provider profiles.

You may contact Ken Cabral, WR QI Director at 203. 805.7445 or kenneth.cabral@ct.gov; Jadwiga Goclowski, SR QI Director at 203.294.5048 or Jadwiga.goclowski@ct.gov; or Brian Dion, NR Assistant Regional Director at 860.263.2495 or brian.dion@ct.gov.

Individual Planning - Changes to Periodic Review Requirements

Reduction in Periodic Review Meetings

Effective January 1st, 2008, DDS will no longer require all teams to hold ***quarterly or six month meetings*** to review individual plans. Individual plans will be updated annually at a team meeting or more often if an individual's needs change during the year resulting in a change in services. This change will reduce required meeting time and enable case managers and other team members to dedicate more of their time to consumers and their other duties. The change does not apply to Community Training Homes and to ICF/MR settings. Those providers will continue to complete quarterly reviews of individual plans.

Six Month Progress Reports Required

As an alternative to team meetings, providers of residential and/or day supports will be required to submit a written six month progress report to the case manager **and** other team members prior to the annual plan and six months thereafter. At a minimum, other team members who should receive the six month reports are the individual's family and the residential or day providers. (i.e. the day provider should submit their report to the case manager, family, and residential provider and the residential provider should their report to the case manager, family, and day provider).

When to Convene the Team During the Year

Teams should meet at least annually to update the Individual Plan. Team members should inform case managers at any time an individual's life circumstances or needs change resulting in a need to convene the team to change the plan of services. Teams should meet when:

- The individual or family requests a meeting, for example to plan a different outcome, new service, or different provider
- The person's needs change resulting in an increase or decrease in services
- One or more new service is added or discontinued
- There is a change in a service provider or vendor.

Quality is an Ongoing Process

The reduction in the frequency of meetings should have no impact on the quality of services an individual receives. Individual team members should continue to monitor individual's health status and progress on teaching strategies and behavioral plans according to the person's specific needs. Case managers will continue regular visits and ongoing monitoring of each individual's situation, services and progress.

Standard Form Committee Representatives Requested

DDS is requesting 3 representatives from private providers of day and residential services to participate on a committee to develop the standard six month progress report form which will be used by all providers effective July 1st, 2008. The committee will also include DDS representatives. Please submit suggestions for private provider representatives to Terry Cote at terry.cote@ct.gov by **February 4th**. The committee is expected to convene in February. At the conclusion of the committee's work, the standard form will be shared along with revisions to procedures that describe monitoring and review of plans and services. Service providers should continue using current forms until the standard form is issued.

Note for CLA Providers

Providers of residential services in Community Living Arrangements (CLAs) received notice, dated December 20th, 2007, to request a waiver of the licensing regulation which requires quarterly reviews of the individual plan. CLA providers should submit those waiver requests to Dan Micari, Director of Quality Management Services in the DDS Central Office. CLA providers should submit requests for waivers by February 1st.