TRANSITION TO INDIVIDUALIZED HOME SUPPORTS
MAY 14, 2013
Questions

1. **Why is DDS revising the IHS program?**
The Center for Medicaid Services (CMS) expects all states that receive federal reimbursement for developmental services to develop a fair and consistent funding mechanism for each participant. DDS has been working with private providers on developing a standard rate system based on a person's level of need. After several years of work, a Legislative Rate Study Commission was established to review the information and make recommendations. The report is available on line at: http://www.ct.gov/dds/lib/dds/operations_center/rate/lac_final_report.pdf.

The finding of the Commission was that "CMS has articulated its requirements to states in the regulations for the Homes and Community Based Waivers. Waiver regulations require that states have a uniform rate setting methodology for service models; that states pay only for services actually delivered; and that states afford service recipients freedom of choice between service providers in order for the state to qualify for FFP (Federal Financial Participation)."

2. **What is the transition process to Level OF Need rates?**
The Commission recommended that "A multi-year transition period will allow agencies to develop and implement strategies to deal with the rate differences depending on their historical funding. At the conclusion of the transition period, all services would be paid based on the uniform rates." Commissioner Macy has given the directive for a seven and one half (7 ½) year transition period for day services beginning on January 1, 2012 to allow private agencies to develop and implement strategies to deal with the difference between a standard rate based on a participant's level of need and the provider's historical funding. The transition for Residential Services is scheduled to begin on January 1, 2013. At the conclusion of the transition period on June 30, 2020, all services will be paid based on uniformed rates.

3. **Have any other services been transitioned?**
The Community Companion Home transitioned a number of years ago. DDS has been working through a private/public staff committee to transition all of its services to a LON based rate system. DDS began the transition with the Day Services on January 1, 2012. The Residential Rate Transition committee determined that the Individualized Home Supports (IHS) program should transition before the Community Living Arrangement (CLA) program.

4. **How is the Level of Need determined?**
   An assessment tool is completed as part of the Individual Planning (IP) process for individuals who receive DDS funded services. The Level of Need (LON) assessment provides the information needed to accomplish the following objectives:
   - *determine an individual's need for supports in an equitable and consistent manner for the purposes of allocating DDS resources*
   - *identify potential risks that could affect the health and safety of the individual, and support the development of a comprehensive Individual Plan to address potential risks*
   - *identify areas of support that may need to be addressed to assist the individual in actualizing personal preferences and goals*

5. **How was the initial IHS rate developed?**
   The IHS rate was developed to reimburse providers for direct and indirect costs associated with direct care staffing support hours. The initial IHS rate developed in 2005 used a standard hourly wage for direct care staff determined by reviewing the Depart of Labor Wage Survey and comparing it with the average hourly wage in the annual report. The standard hourly wage was increased proportionately by established percentages for substitute staff, supervision, benefits, indirect costs and administrative and general expenses. The hourly rate was adjusted over the years whenever a Cost of Living Increase was granted by the CT state legislature.

6. **What was the process for developing the new IHS rates?**
   A Residential Rate Transition Steering committee was formed in February of 2012. The steering committee formed six subcommittees to analyze and propose a new rate methodology for the residential programs to allocate funds based on the individual's Level of Need. The IHS subcommittee had representatives from the private providers, DDS, a self-advocate and a parent. The Committee set the following goals:
   a. *To define cluster apartment setting.*
   b. *To define Family Supports.*
   c. *Develop support hours that correlate to LON Scores.*
   d. *Develop a rate methodology that incorporates all the costs associated with individualized home supports (on-call supports, emergency supports, maintaining an individual's entitlements, housing issues, etc.).*

7. **Are there any changes to the way IHS supports are to be provided?**
   No. IHS supports will continue to be provided in accordance with the current waiver definition.

8. **Why did the IHS committee decide to separate the IHS rate methodology for individuals that live independently on their own from those individuals that live in their family homes?**
   Individuals that live independently in their own home generally are more predictable in terms of support hours because the hours are based only on the needs of the person.

Providers provide the majority of the supports to the individual and are solely responsible for the oversight and coordination of all the person's supports.

Individual's that live with their families or self-directed their own resources receive more diversified supports. Providers are one piece of the supports provided to the individual. The family and the self-directed individual are responsible for the oversight and coordination of all supports.

After the committee reviewed the individual's level of need, the current authorizations and utilization over the past year, there was a large variance between the hours provided to individuals who lived in their own home versus those that self-directed or lived in a family's home.

The diversified nature of family supports requires a more flexible model that will need to be maintained. A separate committee in the near future will be established for a number of stakeholders to include self-advocates, families, and experienced IHS providers to determine a funding methodology based on the person's LON and maintain flexibility for the families.

9. **What are the proposed changes to the IHS program for individuals living independently in their own home that self-direct all of their own supports?**
   There are no changes to the funding allocation methodology for individuals that self-direct all of their own supports.

10. **What are the proposed changes to the IHS program for individuals living independently in their own home with supports provided by a private provider?**
    Individuals living independently receiving IHS supports will be allocated funding based on standard weekly hours according to the their level of need. Healthcare Coordination and Clinical Supports will be available through separate authorizations based on their level of need and PRAT determination.

    Providers will receive a monthly Safety Net amount in addition to an hourly rate for each hour of IHS support provided to the person.

11. **Are all individuals that live independently on their own expected to receive the standard weekly LON hours?**
    The standard LON hours are a maximum number of hours a person may receive during a week. The hours were developed by analyzing the utilization of IHS hours over the past year and subdividing them by individuals with the same LON. Since this is an average, some individuals may be currently receiving less hours. DDS does not think it would be in the best interest of the individual to over support a person just to receive the maximum authorized hours. The goal of the IHS program is for the individual to live independently as possible. IHS participants should have meaningful goals and show progress moving towards independence. The committee realized that sometimes individuals require some additional supports over the year for a variety of reasons. In order not to overcommit

resources for these occasional additional support needs, the committee has developed a process to allow for individuals to access a reserve pool of hours to be used for additional supports when needed without having to receive approval from the Planning Resource Allocation Team (PRAT).

The maximum standard weekly LON hours are:

LON	Hours/wk
1	14
2	17
3	20
4	23
5	28
6	36
7	42
8	48

12. What are Reserve Hours?

Individuals that are not at the maximum standard weekly LON hours will be able to access hours that will be reserved for the person to be used for enhanced or emergency supports. Either 30% of the difference between the maximum LON hours and the authorized hours or 50% of the authorized hours whichever is less will be reserved for the individual. The Reserved hours will not need to be approved by PRAT.

13. How will an individual access the Reserve Hours?

The individual's planning and support team will meet and determine if additional support hours are required. The Case Manager will work with Resource Management to issue an add hours authorization to the provider for the reserved hours on a per occurrence or end of year basis depending on the situation. Any hours above the reserved amount will need to be approved by PRAT.

14. Is IHS reserve balance for emergency purposes only?

The Reserve hours are for emergencies and other issues that the planning and support team feels is required to meet the needs of the individual during the year.

15. Will unused reserve hours be able to be carried over fiscal years?

No. Reserve hours are based on the authorization at the beginning of the fiscal year. DDS will track the hours over the year. Any unused hours will not be allowed to carry over to the next year.

16. Will individuals at their maximum standard weekly LON hours be able to access Reserve Hours?

Individuals that are at the maximum standard weekly LON hours will be able to access a total of 20 additional annual hours over their maximum standard weekly LON hours for emergency supports. The Emergency Support hours will not need to be approved by PRAT.

17. How will an individual access the Emergency Support Hours?

The individual's planning and support team will meet and determine if emergency support hours are required. The Case Manager will work with Resource Management to issue an add hours authorization to the provider for the emergency support hours on a per occurrence or end of year basis depending on the situation. Any hours above the maximum 20 hours of emergency supports will need to be approved by PRAT.

18. How will DDS transition from the monthly IHS authorization to the standard LON hours?

Providers will receive an annual authorization for either their current IHS hours or the standard LON based hours whichever is less at the $29.00 rate and an authorization for either the safety net or cluster amount. If the individual is eligible and requires clinical supports, the provider will also receive an authorization for Healthcare Coordination and Behavioral Supports.

For individuals currently receiving more than the standard LON hours, the provider will receive one-time authorizations for additional hours above the standard LON hours. The additional hours would be the difference between the average hours of actual utilization for the past year based on the WebResDay attendance for the period from January 1, 2012-March 31,2013 and the standard LON hours. The agency would be paid at the $29.00 per hour rate. A person's total potential FY 14 authorizations (IHS, safety net/cluster, Healthcare Coordination, Behavioral Supports and one time add hours authorization) cannot exceed their FY 13 total IHS authorization due to the one-time add hours authorization.

Example:

John has a LON of 3. His attendance for the period of 1/1/212 -3/31/2/13 totaled 1300 hours. The 1300 is divided by the fifteen months of attendance to equal 86.67 per month. This is multiplied by 12 months to get the average annual attendance which is 1040. This equals 20 hours a week which is the maximum amount of hours for an individual with a LON of 3. John will be authorized for 20 hours a week. John and his team will have access to 20 hours of emergency support hours.

Sheryl has a LON of 3. Her attendance for the period of 1/1/212 -3/31/2/13 totaled 1600 hours. The 1600 is divided by the fifteen months of attendance to equal 106.67 per month.

This is multiplied by 12 months to get the average annual attendance which is 1280. This equals 24.61 hours a week which is more than the maximum amount of hours for an individual with a LON of 3. The individual will be issued an annual authorization for the 20 hours and will be given a one- time add hours authorization. The one time authorization is calculated by taking the difference in hours between the standard LON hours of 20 hours per week and the average utilization of 24.61 hours per week for a total authorization for 239 hours. The provider will work with the panning and support team during FY2014 to titrate down to the standard LON hours.

*Pat has a LON of 3. Her attendance for the period of 1/1/212 -3/31/2/13 totaled 1000 hours. The 1000 is divided by the fifteen months of attendance to equal 66.67 per month. This is multiplied by 12 months to get the average annual attendance which is 800. This equals 15.38 hours a week which is less than the maximum amount of hours for an individual with a LON of 3. The individual will be issued an annual authorization for 15.38 hours per week. In addition, the individual and his planning and support team will have access to a number of reserve hours. The reserve hours will be calculated between the standard LON hours of 1040 annual hours minus the annual hours for Pat's annual authorization (15.38 * 52=800). The reserve hours equals 30% of the difference between them (1040-200=240) or 80 hours.*

19. How would it have been possible for a participant to have received more IHS funding with the one-time additional hours authorization?

DDS determined an IHS hourly rate for each person. For individuals with an individual budget, DDS used the rate listed on the Vendor Service Authorization. For individuals on the contract, DDS analyzed the utilization for each participant for the last year. The rate was calculated by dividing the total annual hours provided to the individual according to the WebResDay into the total annualized IHS funding. The analysis identified a wide range of rates from $2.96 - $325.15 per hour. The reason for the large variance was due to utilization. Those with a minimum annualized amount and reported having received a large number of hours of support over the year calculated into an extremely low hourly rate.

For July 1, 2013 providers with an hourly rate calculated to be below the new IHS rate of $29.00 will receive an authorization for the standard LON hours at the new rate. This will increase the provider's reimbursement on a per hour basis. If DDS authorized an additional add hours authorization for the total amount of hours above the standard LON hours at the $29.00 rate, the provider would receive more than the FY 2013 annualized funding amount. Consequently, DDS will authorize additional hours for the add hours authorization only up to an amount that equals the total FY 2013 annualized authorization. Providers will be expected to provide the same amount of supports to the

individual in FY 2014 as was done in FY 2013 while they work with the Planning and Support team to titrate down to the LON hours.

20. What are the proposed changes to the IHS program for individuals that live in their family homes?

There are no changes to the funding allocation methodology for individuals that live in their family homes. However, current individuals receiving IHS supports in a family home may see their budget amount reduced due to a decrease in the IHS rate. The total number of hours of supports will not change.

21. Why was the IHS rate decreased?

In previous IHS rate committee work, providers were surveyed to determine a more accurate reflection of the direct and indirect costs. The new IHS rate methodology reflected the new indirect percentages and updated the benefits and administrative and general percentages. The lower hourly IHS rate is offset for those agencies providing supports to individuals that live independently by a monthly Safety Net amount.

22. What is the Safety Net rate?

The Safety Net rate is a monthly amount available only to private providers that provide IHS supports to an individual living independently on their own. The Safety Net rate is to reimburse providers for:

- *Providing 24 hour (on-call) accessibility of staff.*
- *Providing emergency supports.*
- *Maintaining an individual's entitlement funding and Medicaid benefits, etc.*
- *Assisting in maintaining adequate housing.*

The Safety Net Rate will be paid as long as a unit of IHS support was provided for the month.

23. Why is the Safety Net Rate not available to providers that provide IHS supports to an individual that self directs their own supports or an individual that lives in their family's home?

Since the family and/or the self-directed individual are responsible for the oversight and coordination of all supports, providers are only one part of the total support package and are not expected to provide 24 hour (on-call) accessibility of staff or maintain an individual's entitlement funding and Medicaid benefits, etc.

24. What are Cluster Supports?

Cluster Supports provides individuals that live independently on their own and require access to on-site overnight staff for health and safety reasons access to a direct support staff during the 11:00 p.m. – 7:00 a.m. time period. Individuals that qualify will require a minimum LON score of 3. The cluster consists of 3 or more separate dwellings within walking distance from the overnight staff.

25. **Can an agency provide Cluster Supports if the staff is attached to a CLA/CRS?**
No. The overnight staff attached to a CRS/CLA setting would not be available for reimbursement through the Cluster Supports since the staff is paid through the all-inclusive CLA/CRS monthly rate.

26. **How is the provider reimbursed for the Cluster Supports?**
Providers would receive a monthly amount for each eligible individual to fund the Cluster Supports as long as they provided one unit of support during the month to each person.

27. **Does the provider receive a Safety Net rate in addition to the Cluster Support rate?**
The provider will receive one combined monthly Cluster Support rate that will include reimbursement for the Safety Net.

28. **The definition of Cluster Supports states that the overnight staff must be within walking distance to the participant's homes. Are you looking at defining proximity of location?**
The IHS committee was very clear that the overnight staff should be within a short distance from all the homes within the cluster. The Cluster Supports concept was designed to allow the participant to have immediate access to staff. The committee felt that traveling by car even a short distance could be delayed by traffic or bad weather. While the definition of proximity was not specifically identified, it would be reasonable to expect the length of time to walk from one individual's home to another would be no more than 5-10 minutes.

29. **Are you looking to utilize technology to monitor certain sites?**
Technology may be one strategy to use in a cluster setting but it should not be a replacement for immediate access to staff. The use of monitors or sensors that have been approved by the Human Rights Committee may alert the overnight staff to a possible medical or behavioral issue. The staff would then make the judgment call as to whether he/she should walk over to the home and check on the individual.

30. **The Cluster Support has two rates, one for 7 individuals or less and the other for 8 or more individuals. Does this mean that my agency must have at least 7 individuals in a cluster?**
This new support was created to support the DDS mission to promote meaningful opportunities for individuals to fully participate as valued members of their communities. Cluster Supports was developed to provide another option in the residential continuum to allow eligible individuals access to overnight staff. It was designed to promote independence but provide additional oversight for those that may need that little extra support to be successful in the community. The rate was developed based on 7 individuals

in a cluster. A private provider may have more or less than 7 in the cluster. A provider will need to determine the cost to provide the cluster supports and the number of participants needed to make it a viable program.

31. **What if the provider does not want to have 7 people in a cluster?**
    A provider will need to determine the cost to provide the cluster supports and the number of participants needed to make it a viable program.

32. **What if one staff has several people calling at one time?**
    The staff will need to provide supports to the participant with the most urgent needs. If there are multiple needs that rise to an emergency, the staff should use their agency's emergency protocols.

33. **How will the transition to IHS rates affect individuals that receive Personal Supports?**
    Personal Supports will continue to be a qualified support. Providers that provide an individual with personal supports will continue to receive the current Personal Support rate.

34. **Will the number of Personal Support hours change because of the standard weekly LON Hours?**
    Personal Support hours will be allocated based on the IHS LON support grid. Personal Support hours will be prorated to reflect the lower hourly rate. One hour of IHS supports is equal to 1.1 hours of Personal Support. (10 hours of IHS supports equals 11 hours of Personal Support).

35. **If an individual only receives Personal Supports will the agency receive the Safety Net Rate?**
    If an individual only receives Personal Support, the private provider will not receive the Safety Net Rate.

36. **Will an individual that is provided personal supports be able to access the reserve or emergency support hours?**
    Yes. The same methodology will be used to determine the number of reserved or emergency hours.

37. **There seems to be some confusion as to when to provide IHS supports and when to provide Personal Supports. Is this being looked at?**
    DDS will work with providers to develop clear definitions of the difference between IHS and Personal Supports. The IHS Committee will be addressing this issue in the coming months.

38. My agency's monthly IHS payment included Nursing and Behavioral Supports for individuals who required these services? How will these services be reimbursed in the new IHS Rate Methodology?

The transition from a monthly payment to an hourly payment will require the unbundling of services provided by the private provider. Individuals that require Healthcare Coordination and/or Behavioral Supports will be issued a separate authorization in addition to the IHS authorization. The Healthcare Coordination rate is $71.71 per hour and the Behavioral Consulting rate is $121.20.

39. What is the difference between direct nursing supports and Healthcare Coordination?

Healthcare Coordination provides the clinical and technical guidance necessary to support the participant in managing complex health care services and supports to improve health outcomes and prevent admission to a nursing facility.

Support provided includes, but is not limited to, the following: train/retrain staff (if utilized by the participant) on interventions, monitor the effectiveness of interventions, coordinate specialists, evaluate treatment recommendations, review lab results, monitor, coordinate tests/results, and review diets. Direct nursing supports provide skilled nursing services to the participant. Direct nursing supports should be provided through Title 19 insurance and the Medicaid State plan.

40. How is it determined whether an individual can or cannot receive Healthcare Coordination?

This service is only available to individuals with identified health risks who receive less than 24 hour supports. Authorized hours for Healthcare Coordination will be based on the person's LON scores. Hours of service that exceed the automatic authorization level must be submitted to the regional Utilization Resource Review committee for prior approval.

LON Score
*Health/medical score **4 or higher***
*Score of **6 or higher** for combination of: health/medical **and** either the behavior (home) or psychiatric (home) domains, whichever is higher.*

Authorized hours of service per year:
Score of 4-6 - 24 annual hrs.
Score of 7-9 - 36 annual hrs.
Score of 10-14 - 48 annual hrs.

41. How will Healthcare Coordination hours be reimbursed?

Providers will be issued a contract service authorization for Healthcare Coordination. The providers will input the service hours into the WebResDay on-line attendance program. The reimbursement will be included in the monthly contract payment process.

42. If a medical appointment needs to be done and it is several hours over the planned hours, would that be reimbursed through the Safety Net?

Staff that accompany participants to medical appointments are billed at the IHS rate for the total number of hours provided to the individual.

43. Isn't annual health care assessment required?

Individuals receiving medical supports through community practitioners require an annual physical by the participant's physician/APRN/PA on a separate DDS form as part of the individual's annual assessment. Individuals receiving Healthcare Coordination from the provider are required to complete an annual health assessment. The provider's nurse completes 1 – 2 pages of a nursing assessment annually, which is a component of the annual physical packet that the physician completes.

In addition, a nursing or physician assessment is required when there is a change in condition. A nursing assessment is required when a person returns home from a hospital stay; however, the nurse has 72 hours to complete the assessment. There isn't a specific form required for this assessment, some nurses use a form or document their assessment in focus charting. When transferring to another agency, a Nursing Health & Safety Assessment packet is completed.

All private nurses were required to complete a baseline Fall Risk Assessment on all clients who do not reside at home or did not meet the exclusion criteria. (Outlined in the Nursing Process and Nursing Documentation documents)

44. When should a provider use a visiting nurse agency?

In settings without 24 hour supports, community practitioners such as the visiting nurses covered through the Medicare/Medicaid state plan should be the first option. Individuals that have complex medical needs and require nursing supports to prevent the individual from moving into an institutional setting can receive Healthcare Coordination.

45. How are visiting nurses reimbursed?

Visiting Nurse Agency (VNA) bills Medicare for services if the person is homebound; they bill Medicaid for other nursing visits, but the visits are limited (i.e., 12 visits per month).

46. Can the VNA fill out the required DDS nursing reports?

When VNA initiates services, they complete a nursing assessment; however, they also complete an assessment with each visit except for visits limited to medication administration. The VNA completes a 485 form (Doctors Orders) every 60 days; the VNA nurse will provide a copy of that form to providers upon requests. The VNA uses a "visit form" for every visit, they don't typically leave copies of this form, but they will if requested.

VNA does not complete DDS forms/reports, but as stated, when requested they will leave a copy of their forms. As far as yearly individual plan write ups, the VNA will not usually do that.

47. **What if an individual self-medicates, do they need a Healthcare Coordinator?**
When an individual self-administers medication, they will need some support from a Registered Nurse. Whether or not Healthcare Coordination is provided depends on the specific needs of the individual as identified in the individual plan and the correlating LON score. Ultimately, competency to self-administer medications is based on the assessment of a Registered Nurse. VNA will provide support in terms of filling pill boxes.

48. **If an individual does not receive healthcare coordination, how does the provider get reimbursed for providing nursing supports?**
As stated previously, community practitioners such as the visiting nurses covered through the Medicare/Medicaid state plan should be the first option. For individuals that require clinical and technical guidance necessary to support the participant in managing complex health care services and supports to improve health outcomes and prevent admission to a nursing facility, the individual would require Healthcare Coordination. All other typical nursing tasks would be reimbursed through the IHS rate.

49. **How is it determined whether an individual can or cannot receive Behavioral Supports?**
Behavioral Support is defined as those therapeutic services which are not covered by Medicaid or Medicare, and are necessary to improve the individual's independence and inclusion in his or her community.

Behavioral Supports will be based on the behavioral support needs of the person. When an individual is identified by the team to require Behavior Support services, the authorized annual hours will be based on the person's LON scores, PRAT approval and the hours to support maintaining the behavioral plan. The development of the plan will be funded through a one-time authorization by PRAT.

The use of when an individual requires Behavioral Supports depends on the support needs of the individual. A significant number of individuals in the IHS program do not require any Behavioral Supports. A review of the data for the current use of Behavioral

Supports in the entire IHS program was not available since private providers reimbursed for providing these supports through the monthly IHS payment were not required to document the number of hours provided to the individual on the WebResDay on-line attendance program. DDS has developed an interim set of guidelines to be used when determining the annual amount of Behavioral Support hours to provide an IHS participant. These are only guidelines. PRAT will be able to authorize additional annualized hours based on the support needs of the individual.

Guidelines for the annual hours of Behavioral Support hours per year:

- *a. Behavioral Composite Score of 1-2 - 0 annual hrs.*
- *b. Behavioral Composite Score of 3-4 - 2 annual hrs.*
- *c. Behavioral Composite Score of 5-6 - 4 annual hrs.*
- *d. Behavioral Composite Score of 7 - 8 annual hrs.*
- *e. Behavioral Composite Score of 8 - 12 annual hrs.*

50. These guidelines appear to be very low for providing Behavioral Supports. Why is that?

The guidelines were developed based on the support hours needed to review and maintain a Behavioral Support plan. These are only interim guidelines. These will be reviewed after one year of data to determine an average number of hours of Behavioral Support provided to individuals within the Behavioral Composite score range.

51. How will a Behavioral Support initial assessment be reimbursed?

Individuals that would require an initial behavioral assessment would request a one-time authorization from the region with the number of hours required to complete the assessment.

52. Regarding the initial Behavioral Assessment one-time authorization process. If the plan requires additional hours, does the provider have to submit for another one-time authorization?

Yes. If the provider completes all the hours in the one-time authorization then an additional one time authorization must be submitted. The approval of the additional one time authorization is not guaranteed and the provider should keep the region informed if it looks like additional hours will be required.

53. If the initial Behavioral Assessment is reimbursed through a one-time authorization, what behavioral supports are covered through the guidelines?

Behavioral supports covered through the guidelines includes analyzing data for an existing Behavioral Support plan, revising plan in accordance with the data, on-going PRC documentation and working with the psychiatrist.

54. What if the individual I support requires additional Behavioral Support hours?

The provider will work with the region to determine the specific number of support hours the individual will require for Behavioral Supports.

55. Will the WebResDay have a category called Behavioral Support?

The WebResDay will be revised to include all the new service categories being moved over from individual budgets. These include Personal Supports, Adult Companion, Behavioral Consulting, and Healthcare Coordination.

56. Can the billing for Behavioral Support include some indirect hours?

The required services should be identified in the Individual Plan. Time for reviewing records, preparing reports, and consultation over the phone is allowable. These activities must be clearly discussed and agreed upon with the team. Time spent with the person, consulting and training with direct support staff and family members should be the predominate billed time. Non-direct activities cannot make up more than one third of the time in a month without written approval from the region. Time spent on activities related to billing, payment, scheduling of appointments, travel time and service documentation are not billable; they are built into the rate. As services are provided in the community, the person's own home, or a family home, the provider documents the delivery of services for each date of service. The documentation includes the date of service, the start time and end time of the service for each date, a signature of the person providing the service, and documentation including the reason for the service, the outcome, and follow up activities. Service documentation must clearly delineate whether the time was face to face with the service recipient.

57. Regarding VSP – Are behavioral hours a separate authorization?

Yes. Behavioral Consulting will be issued a separate authorization for all IHS programs.

58. Does my staff need to be qualified to provide Healthcare Coordination and Behavioral Supports?

Yes. Every individual staff that will be providing Healthcare Coordination and Behavioral Consulting must have gone through the qualification process in order for the provider to bill for Healthcare Coordination and Behavioral Consulting. The process to become qualified is at the following link on the DDS Website: http://www.ct.gov/dds/lib/dds/operations_center/how_to_apply_to_become_a_qualified_provider_individual1.pdf.

59. My staff is not currently qualified to provide Healthcare Coordination and Behavioral Consulting. It will take my agency longer than July 1st to get them

qualified. Is there a process to maintain these supports for the individual while the agency works through the qualification process?
Yes. Providers will work with their region and determine the specific hours currently being provided to the individual and at the agency's actual costs. The region will issue a one-time authorization for six months to allow for time for an agency to have their staff get qualified.

60. **Will the one-time authorization be able to be extended if a problem develops during the qualification process?**
The regions will have the authority to extend the one-time authorization for an additional amount of time up to six months to complete the qualification process.

61. **How will some of individual supports be represented in the Op Plan – re: Behavioral Support, Nursing Report?**
Providers must have a separate cost center for each waiver support category (CLA – by each house, CRS – by each house, IHS, Personal Supports, Adult Companion, Healthcare Coordination, Behavioral Consulting, DSO, GSE, Sheltered, ISE, Individualized Day – vocational and non-vocational may be combined).

62. **Regarding the process of converting from an individual budget to a POS contract – Will the agency receive an authorization?**
Yes. All providers will receive a contract service authorization that details the name of the individual, the support, the effective date, the number of authorized hours, and the annualized dollar amount.

63. **How does the case manager reflect on the IP?**
This should be reflected just like any other service. All that would be in the IP6 of the IP is the services received, who's providing the services, how many hours, etc.

64. **If some residential supports are self-directed and the individual receives IHS services from a provider, will the provider receive the Safety Net?**
In general, if a DDS participant self-directs any part of the residential services then those services will remain on an individual budget and will not be moved over to the contract. If the individual self directs the day services but the residential services are provided solely by a private provider, then the residential services will be moved over to the contract.

If the provider is providing IHS supports then it would be eligible for the Safety Net monthly amount.

65. How are families going to be notified of the changes to the IHS program?
DDS will be sending out a letter to all families informing them of this change.

66. Regarding WebResDay, will the agency be able to bill for hours above the weekly standard LON hours as long as the total annualized number of hours is not exceeded?
Yes. DDS understands that the IHS program is very flexible and supports hours should be based on the needs of the participants. Providers may bill over the standard LON hours on any given month as long as the total annual hours are not exceeded. DDS will be analyzing attendance each quarter and will inform providers and case managers whenever an authorization is trending higher than the standard LON hours.

67. Will a provider be able to bill for more hours than authorized for Healthcare Coordination and Behavioral Supports?
A provider may only bill for the total number of Healthcare Coordination and Behavioral Supports hours they have been authorized to receive. The provider may bill more than the monthly total in a given month so long as the total annual hours are not exceeded. If additional hours are required, the case manager will need to go to PRAT and request additional hours for the participant.

68. Are VSP participants moving from individual budgets to the POS contract?
*Participants whose supports are provided solely by a private provider are moving from individual budgets to the contract. Participants that self-direct any portion of their residential budgets will remain on individual budgets. This rule applies to all DDS participants including VSP individuals***.**

69. My agency will receive a reduction in IHS funding due to the change in IHS rate methodology. My agency has also been identified as being a low rate provider for CLA supports. Can a provider transfer the reduction savings from the new IHS rate methodology to offset low rate CLA authorizations?
Yes. The Department will allow providers that have been identified by DDS with funding below the CLA rate guidelines to transfer the calculated reduction from their total IHS funding to their CLA program. Providers will work with the regions to identify individual authorizations to increase in their CLA program.

Providers that are calculated to receive a reduction but their CLA program has been identified at or above the CLA rate guidelines will not be able to transfer the reduction savings.