Shawnee County CDDO
Affiliate Meeting
June 13, 2016

Present: Mark Gonzalez, Mosaic; Jon Gerdel, Life Patterns; Coleen Hernandez, CDDO; Robert Smith, CDDO; Sabrina Winston, CDDO **Scribe**: Billie Padilla, CDDO

Phone: Merilee Larson, Lifeworx; Stacy Bleidissel, Advanced Individual Services

I. CDDO Updates:

- April 2016 and May 2016 Affiliate Report Overview – See Attachments
- KDADS draft policies that are shared for comment (within the 10-day comment period) can be sent to the CDDO to be included with the other comments submitted to the State. Please see attachments.
- The I/DD Rate Study is completed every three years. Myers & Stauffer, the accounting firm that prepared the study, held a webinar on June 9th to share their findings. Providers shared that there are significant flaws in the report as it did not identify hours that are not accessible nor did it use staff from hospitals or nursing homes, as a baseline as well as other discrepancies.
- The State's Transition Plan that was submitted to CMS was denied. There were many concerns. If you are interested in participating on the group to address some of the issues and work on a revised plan for CMS please submit your name and information to the helpdesk@kdads.ks.gov.
- The state will post the Transition Plan on their website after it has been written.
- There was a brief discussion on the surveys that the State sent out. Some providers participated in the survey again to make sure that their information was received. The State will be conducting on-site visits slated to be completed by July 31, 2016.
- Waiting List Update – ten individuals have been offered services in Shawnee County. No information has been shared on how many in the State.
- New KDADS Program Integrity Compliance (PIC) staff will be meeting with Sabrina to discuss CDDO functions and may also attend some BASIS assessments.

II. Guest Speaker:

- Dan Hermreck, TARC Training Coordinator. Dan gave a presentation on Ethical Issues Relating to marketing (see attachment).

V. Upcoming training opportunities

- June 30th – SNCDDO Quarterly Training 8:30-12 TARC Board Room
- BCI Training - TBD

Next meeting is August 8, 2016 at 2 pm

April 2016
Shawnee County CDDO Affiliate Report

Individuals receiving service: 1051
862 adults; 189 children

- 278 Receiving in home supports
- 590 Receiving day services
- 495 Receiving residential; 482 adults, (13 children's residential)
- 995 Receiving TCM

Determined Eligible: 1

Determined Ineligible: 1

Re-entry: 4

Incoming Transferred: 2

Outgoing Transferred: 0

Individuals in Crisis Year to Date: 14
(July 1, 2015 - June 30, 2016)

Crisis Request Reviewed: 6
Crisis Request Approved: 1
Crisis Request Denied: 2
Crisis Request Pended: 3

Individuals exiting Medicaid Services: 0

Provider Changes

- **Day**: 8
- **Residential:** 4
- **Case Management**: 13
- **In-Home Support Providers (FMS, SHC)**: 4

Individuals not yet selecting case management: 56

Medicaid Eligible: 36
Non-Medicaid Eligible: 20

***Note:** Due to POC process changes, provider change information is uncertain at this time.

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Conflict of Interst Policy		
Policy Section	Comments	Authors
General Comments	The policy section makes it sound like every situation must be presented to the court for approval/non-approval. Currently, people in our area are just getting the designated representative forms signed and not even trying to get the courts approval.	
	· Under the procedures section, it indicates the legal guardian or DPOA must designate a representative to direct the services. This is conflicting with the information in the policy section.	
	· With relation to the form noted in the procedure section, does the form attached replace the old form that was part of the previous policy?	
	· Under procedures, item 2d it indicates the designated representative (DR) must attend IEP meetings. This policy/issue has to do with HCBS services, why would it be necessary for the DR to attend the IEP?	
	Policy is difficult to follow and could be streamlined. Most of it seems to address self-direction, but summary statement indicates it is more far reaching but doesn't speak to it in the procedures. Summary statement is not about self-direction but rather an HCBS provider cannot also provide TCM. Seems poorly written.	
	Generally, very hard to read...had to read some sentences a few times to determine what they meant and some still didn't make much sense. Summary mentions case management and developing the PCSP, but the policy was about self-direction and appointing a rep if needed, no mention of conflict with TCM. Case management is only mentioned 2X and both were in the Summary	
	The summary paragraph at the beginning of this policy references CMS regs on TCM services in regards to HCBS providers but the policy is actually about addressing guardian and DPOAs conflict of interest in regards to being a paid support. The summary paragraph should instead reference CMS regs on guardian conflict of interest as a paid support. To leave as is, will create great confusion for both providers and families as the summary paragraph and actual policy are stating completely different things.	
	Third paragraph - This paragraph indicates the service coordinators and personal agents who identify situations in which a conflict exists must provide the information to the individual and the legal guardian to address the conflict. Is the information referenced in this section a copy of KDADS Conflict of Interest policy and the associated forms (Appointed Designated Representative Form, Designated Representative Revocation/Reassignment of Responsibilities Form)? If not, what is the information? This needs to be identified in this paragraph.	

Residential Billing Policy		
Policy Section	Comments	Authors
General Comments	To summarize-the state wants us to place everyone in independent work and living and then pulls most or all funding for doing so. What's the incentive here? I have several issues with this proposed policy change. For those people who live independently we would NOT be able to bill every day for the Residential services UNLESS the MCO has a written POC that includes at least ONE direct staff encounter every single day. This would be a very unusual scenario for someone living in their own apartment. Especially on the weekends. ALSO the whole idea of having to contact the MCO every time there is a Crisis to have that single encounter Added to the POC temporarily so we would be able to bill is ludicrous and would be impossible to manage from both sides. Currently we are able to bill EVERY day of the month for having Staff "ON CALL". If you have staff "ON CALL" you Have to pay them regardless of encounters or Crisis situations, with this new policy you would not have funding to cover that Staff On Call time. We have been told over and over, by the state, that they are aware that other Tier Levels are inadequately funded and by combining the potential savings from billing this population for being on Call, this makes up for the extra staffing required for serving the higher needs (under funded) population. Most importantly, once again the State is moving AWAY from the Independent Living Model by removing funding that would potentially create health and safety issues by allowing the MCO's to determine the level of encounters that would be allowed to folks living Independently.	
	How are they defining a "service", is it anything defined in the PCSP as a support/service needed?	
	With regard to the backup plan, what are they referring to?	
	Requiring actual service provision, and eliminating "availability" as eligibility to bill, will result in more congregate settings, loss of client independence, and likely loss of services.	
	Likely loss of Residential Support providers, or providers establishing they are at capacity.	
	Realize that the negative effects will not stop at the provider level, but will effect persons receiving supports.	

TBI Program Eligibility Policy		
Policy Section	Comments	Authors
C.3.d	Add "based" between the words community and waiver.	
C.8	Change HCBS-TBE funds to HCBS-TBI funds	
Definitions Primary Diagnosis	Update the statute reference to insert the correct location within statute to replace (qqqq) or delete this information.	

	If a crisis does occur that results in exceeding the POC, the MCO will have to revise the POC to allow the provider to bill.	
	MCOs have a poor track record of revising billing/payment process, and would have to make such revisions retroactive-MCOs say they will not do retro adjustment.	
	This is a significant change for persons served and when redefining service in this manner would expect waiver revision that should require public comment.	
	Need clarification that there is no change to the unit.	
	Concerned residential providers will be required to be available, maintain capacity with no reimbursement. You cannot transform a rate system built on averages in this manner and not effect financial stability of providers.	
	New language speaks to expectation that the provider is available and expected to provide response to crisis with little assurance payment will be approved.	
	I am concerned that such a major policy change would significantly impact capacity for Residential Supports. One provider has informed me that all three MCO contracts require the provider to be on-call 24/7. Another provider has voiced concerns regarding the continued requirements of a provider to respond to and meet consumers' needs 24/7 for KDADS licensure as a Residential provider. Changes to provider pay for a service that has not seen a rate increase in nearly 10 years while maintaining requirements for on-going monitoring and indirect support may force providers to no longer offer that service. We have been fortunate in our CDDO area to have providers who offer an array of residential support options rather than a one size fits all service. This policy change will result in decreased options, decreased capacity to meet the number of consumers receiving residential, and will force consumers into either more restrictive service settings or to self-directed services that do not meet their full needs or to go without services.	
	We would like to see this in an actual revised policy format and not "go to the IDD Manual and add this and remove that".	
	Residential providers cannot bill for services unless a residential employee provides a service, in person, to the participant that day.	
	Question- does the service have to be provided in the person's home? What if they are transported, met at a community location, etc.	

	Clarify that we'll still be paid the full daily rate if:	
	A. The client is present B. Our staff is present with the client C. We provide a billable service D. We are paid the full daily rate whether the service takes 5 minutes or 24 hours (i.e. – no "units" as in day services are involved)	
	What will be considered to be acceptable documentation of the service provided? Is there a plan to change the documentation requirements?	
	Confirm that the current number of days authorized in the Plan of Care are still eligible for billing as long as the above requirements are met.	
Edit 1 & 2	The concept of averaging appears to no longer be supported by this Administration. Every agency has individuals they support who require greater supports than their rate will fund. When the rate structure was developed many years ago, it was explained that the cost to provide services to some individuals may be fully funded by the daily reimbursement rate, however the cost to serve others may not be fully funded and through averaging, the funds received should be sufficient to cover the cost of services for individuals on the I/DD HCBS waiver. The exception to this is for individuals who qualified for EF. (Edit 1 & 2).	
Edit 2	In bullet one of Edit 2, insert the word "provider" between residential and employee so it would read: ". . . unless a residential provider employee provides . . ." (Edit 2)	
Edit 2	How will the number of residential support days to be placed on the ISP be determined? (Edit 2)	
Edit 2 & 3	In crisis situations, it is suggested the MCOs have a small number of decision making (working) days (3-5) to approve/deny crisis requests for additional days of service and the service provider should be notified within the allowed decision making days.. If there is a denial of the crisis request, will there be an appeal option? The update to the ISP should also be made within the allowed decision making days to reflect the approval of additional days of service. It is possible the number of crisis days needed might extend over a range of days depending on the situation, which the MCOs will need to have a process in place to accommodate these type of situations. (Edit 2 & 3)	

Response:

1. We support a number of individuals that live alone in their own apartments. They live in secured buildings and have to answer their phone and admit Direct Support Professionals (DSPs)into the building and into their apartments. It is not out of the ordinary for them to do one of the following:
    - Refuse to answer our call at the front entrance and admit us to the building;
    - Refuse to respond to us knocking on their door;
    - Leave home and make themselves unavailable to services when the DSP is scheduled to be there.
2. Sometimes it is possible for that DSP or another one to connect with the person later in their work day and sometimes it is not. If the individual cancels services at the last minute or with no notice, these guidelines mean that the provider gets no pay for that day. In order to keep DSPs employed, we have to pay them for scheduled hours.
3. When individuals are having mental health issues and are avoiding staff on purpose, they may not be taking medication for mental illness. This may lead to a crisis which requires many hours of staffing per day or per week. How do we handle the crisis and worry about requesting funding to handle the crisis? We are a smaller provider and have limited administrative staff. This would cause us to reduce direct services in order to manage the administration of the crisis funding.
4. The same goes for individuals that have emergency health issues, surgery, etc.
5. Some individuals we support choose to work with DSPs 5 or 6 days a week and have one day off. This puts them in control. However, this does not mean that the person never needs assistance on their one or two days off a week. When DSPs see warning signs that the person needs more support, they call and talk to the person or they may drop in. In these cases, DSPs flex out their hours elsewhere in the week or we pay them overtime. If the person has been doing well, DSPs honor their request for 1 or 2 days off a week. If the person calls for assistance on days when staff are not scheduled, as a provider we figure out how to get a DSP or a supervisor there to meet their needs. We have figured out how to be flexible and make staff available to the individuals we support as we honor their choices and meet their needs.
6. This regulation may force us into the person's life on days when they don't need us. Alternatively, if we don't schedule staff and we don't have staff available, we cannot meet their needs when they call for assistance or when they have an emergency.
7. The system now acknowledges that on some days, an individual can have little to no need for a DSP and on other days the same individual may need assistance around the clock (up to 24 hours a day). As a provider, we are expected to provide the amount of assistance needed and we always figure out how to do it. We know that the funding is coming in every day and on the average will pay for staffing and supports for high service days, low service days, and no service days.
8. Some of the individuals we support in a more independent lifestyle already have a Tier 4 or 5 funding. To remove funding for days when DSPs do not provide services in the home of the person will put these individuals at risk when their needs are high and will result in more administrative time for DSPs and supervisors to request the additional funding.

Ethical Issues relating to

MARKETING

From the Shawnee County CDDO Ethics Committee

- Providers will market services in a manner that does not place people in the middle of transition disputes.
- Providers will not use their unique relationship with and access to people to solicit and influence service changes.
- Providers will ensure the process for transfer of services established by the CDDO is followed.

From the Shawnee County CDDO Ethics Committee

- The provider will affirm times of transition for the people they serve are marked by extensive, mutually agreed upon, and enhanced information sharing, and every necessary decision is made by the person in a free, voluntary and fully informed manner.

Best Practices for Marketing

- A provider affiliated with the Shawnee County CDDO can market themselves through…
  - Requesting a mailing list from the CDDO, and sending out letters.
  - Their websites. (Can request link on CDDO website.)
  - Civic organizations
  - Organized community events. (resource fairs, advocacy groups, etc.)
  - Media (TV, Radio, Print, etc.)

An employee of an affilliated provider can not…

- Inform an individual they support about their own business prospects (starting their own business, a job at another provider.)

If there are violations of these standards…

- A written grievance is filed with the Shawnee County CDDO.
- The CDDO Quality Assurance/Quality Enhancement team will review the grievance and determine if the grievance warrants forwarding to the CDDO Dispute Resolution Committee.
- Upon receipt of a written notice of dispute, the CDDO Dispute Resolution Committee will review request for dispute and provide the opportunity for resolution between the disputing parties within twenty (20) calendar days.