

**Community Living Program Monthly Technical Assistance Call  
July 16, 2009**

Moderator: Tim Engelhardt, The Lewin Group

Participants: representatives from AR, CT, FL, GA, IL, LA, MA, MN, NH, NJ, NY, OH, VT, VA, WA, National Resource Center on Participant-Directed Services, The Lewin Group, AoA Central and Regional Offices

*This technical assistance call was designed as an opportunity for dialogue between states implementing Community Living Programs. In particular, we want to raise a question about integrating different state data management systems and hear about states' experiences with the Veterans Directed Home and Community Based Services Program.*

**Q: How are states' integrating different state data management systems such as Medicaid, ADRC, and NAPIS? What are potential best practices to integration?**

A: Sharon Graham and Lou Ortiz, NJ – We are working with other agencies through a Systems Transformation Grant committee to merge our state's data; it goes beyond the CLP program and will be used for consumer and cost tracking. We are using Harmony software, which will be tailored to our needs. It has been a long journey. Harmony has been meeting with us to figure out the best way to track all the consumers in the system. Most ADRC counties and AAAs have included data in their systems for both ADRC and NAPIS requirements, and we want Harmony to deal with those elements.

A: Leslie, NH – New Hampshire is also using a Harmony software product but not the SAMS component to do demographic tracking and services to MR/DD populations.

A: Debby, AR – We use SAMS for all tracking and ADP for FMS and payroll. We are using 3 systems to achieve one goal.

A: Marc, OH – Our state is having discussions about how to capture ARRA funding to develop statewide data exchange. We are looking at health information technology (HIT) as a model.

A: Jamie, GA – We built our data management system in-house using Y2K funds. Medicaid waiver, non-Medicaid (including OAA) and NHD clients are all in our integrated management system. We can compare all the data across programs and providers can run reports. The data is from 2002 to present.

A: MI – We have a comprehensive statewide ISIS data warehouse system that all the AAAs use. It is used for all client types, billing, etc. Both AAAs and state staff have access.

Heather Johnson suggested that states might group together to talk with Harmony about changes they would like to see in their product. Tim Engelhardt offered to provide a list of the states we're aware of that use Harmony products.

**Q. What is the status of VDHCB implementation in your state in the following areas...?**

*Rate Setting – What are your processes and methodologies? Are you setting individual rates? A flat rate? Tiered rate?*

CT – The AAA, SUA, and VAMC met regularly to prepare for the readiness review and to draft the provider service agreement. The AAA drafted the provider agreement; rates based on Medicare or Medicaid rate (whichever was higher) as a baseline. They are working out the components of the administrative now and they will send that to the VAMC for input. Will be calculating individualized rates based on plan of care.

MI – Basic and intermediate rates are capitated for the first three months, and then the rate will change to correspond to the individual's plan of care. The current average is about \$4200/month for a plan of care. There is variance in the needs of individuals. A capitated approach is not very person-centered. Monthly rate includes 20% admin segment for case management, overhead, and FMS. 3 veterans are being served, 2 are self-directing their care.

NY – In New York, 20% of the care plan budget also goes to admin. They work within a single rate range; if an individual exceeds the range then they are treated as exceptions to be approved at the national VHA office. We are hoping to enroll a case mix of both high end users and low end users.

FL – We negotiated a rate of \$1570 – \$3000; 20% for admin is added on top of that range, and the admin component includes case management. Differs slightly by county; Miami has a different rate and basis on which the budget is determined. We also hope to enroll mixed cases.

MA – In Massachusetts, the VAMC proposed a suggested rate of \$1390/month, which includes 20% for admin (\$62 going to FMS, \$215 to AAA), leaving about \$1057 per person per month for a service budget. Certain people will exceed the suggested rate and they plan to negotiate that on a case by case basis with the VAMC and national VHA office. Also, workman's compensation is deducted from the first month's budget only.

NJ – The local VAMC made up individualized rates. In Somerset County, the 20% administrative component is included, but in Morris County it is added on top. Admin in NJ does not include case management. FMS vendor does some management and individual can select more case management as a part of his or her service plan.

#### *Provider Agreements*

MA – Our agreement outlines expectations. Veterans execute agreements between themselves as employers and their support workers, between workers and FMS, and between veteran and the State.

NJ - Our provider agreements with VA are at the AAA level.

AR – There has been a hold up in executing the provider agreement because the VAMC didn't agree with the provider agreement template that was originally distributed. It began as a two page document and ended up being 30 pages long.

NY - We made only modest changes to the template provider agreement.

FL - Ours is four pages. We just modified performance standards to align with the CMS Quality Framework.

#### *Communication with the VAMC*

CT -- The local VAMC has been very willing to talk; we are still working on building understanding of consumer direction.

NJ - The VAMC has been an eager partner and we have ongoing collaboration. Everything goes to the FMS and the VA is kept aware.

MI - We work well together because the VAMC has remained flexible. We send them the care plans. Clinical team just engages at manager level. Understanding person-centered thinking has been the biggest hurdle because VA staff are used to care plans that address medical needs. We are hosting trainings for both our staff and the VA staff on consumer direction. We hope to serve 50 veterans through the program overall.

NY - We have a very strong relationship; they attend all trainings.

FL - Veterans have the concepts of consumer direction explained to them during the screening process at the VAMC.

MA - We have developed consumer direction handbook because our program requires that all veterans self-direct their care.

#### *Cash Flow and Timing of Claims Payments*

MI - We are billing at the end of each month. We had our first consumer in April and we just received payment. There have been some minor issues with direct deposit, it has not been going very smoothly yet, so we are still working with paper checks. We hope things will improve, go more smoothly, and therefore reduce the waiting time, when these issues are worked out. Right now it takes 15-70 days for payment from VA.

NJ - We've experienced a 6-week turnaround time for payments.

#### *Any surprises?*

IL - I am interested in knowing how states are operating fiscal management? (Respondents indicated that most of them contract out, except AR (does internally at AAA) and FL (uses a sub-agency)). Is this part of the admin component? (YES)

NY - Is it possible to receive TA from the VA on the best way to do billing?

NJ - Be aware that what is worked out at the local level may not meet the approval of the regional level, because there is some disconnect in the vast VA system. Involve the regional VISN from the beginning if possible. You can find the right people to talk to.

NY - Should we be HIPPA compliant at AAA level? (YES)

AR - Why isn't there prospective payment in this system, more like the Cash & Counseling program? (VA has determined that will not meet their needs/requirements)

MN - What are the ages of your veterans who are interested in self-direction of services? (FL - 1/6 veterans is younger than 60 years old. NJ - one is between 30-39, one is between 40-49, majority are 80 and older.)