

Help! My Services have been cut by DMRS

Printer Friendly
Version

Services provided for people with intellectual disabilities and funded through the Division of Mental Retardation Services (DMRS) Medicaid Waiver Home and Community Based Services (HCBS) are being reviewed for the purpose of reducing costs to the State of Tennessee. There are three methods being used to accomplish the action:

1. The implementation of Protocols effective August 1, 2008,
2. The review of all ICAP (Inventory of Client and Agency Planning) Scores, and 3. The Reduction of Payments to agencies or individuals providing supports of the services. (being considered for October, 2008)

The Division of Mental Retardation Services (DMRS) is reviewing all cost plans and may make reductions in intensity (the amount of staffing supports provided), duration (how long the service may be provided) or frequency (how often the service is provided) of services to individuals in the Medicaid Waiver program. This website includes current information from DMRS, your right to appeal the changes in your or your family member's services and a form to use to file that appeal.

The Arc of Tennessee has drafted a Position Statement on these actions. [Read the Waiver Service Reductions Position Paper.](#)

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Introduction

The Tennessee Division of Mental Retardation Services (DMRS) is implementing actions in an effort to lower the cost of services in all Home and Community Based Services Waiver. These actions can have an effect on people receiving supports either by eliminating a service that is needed to assure the safety and wellbeing of the individual or by reducing the quality of services currently being realized by the individual being supported.

The first action involves the review by the DMRS Regional Office of each Individual Support Plan (ISP) to evaluate what services can be reduced or eliminated entirely. You can review the various DMRS Protocols at http://www.state.tn.us/dmrs/provider_agencies/Protocols.html. This review will take place whenever a new service is requested, at the persons annual Circle of Support where an Individual Service Plan is developed, or if DMRS wants to complete a review.

The second action involves the redoing of all Inventory of Client and Agency Program (ICAP) Assessments. In doing so DMRS and assessors are decreasing the Level Of Need for many people receiving supports. This will in effect lower the rate that a provider receives for services and thereby lowering the number of staff that they may have available for services such as residential supports such as supported living and residential habilitation, and day supports such as community participation and supported employment

The third action involves an across the board reduction in rates paid to the providers of services in the statewide Home and Community Based Services Waiver. In the past this only affected people receiving supports through the Statewide waiver, however, it could be applied to people receiving services in both the Self Determination Waiver and the Arlington Class Waiver. DMRS is once again considering this action sometime in October, 2008. While the actual percentage of reduction has yet to be determined, when it does happen this will mean additional reductions in payments to providers and may result in reductions of services, such as staffing reductions, limits on travel for community involvement, or limits of therapy services.

DMRS Protocols

The Protocols have been developed by the Division of Mental Retardation (DMRS) “to guide the determination of service requests.” Each of the Protocols defines who is eligible for each service, how much service a person can receive and the right to appeal if a service is reduced or denied. Approval will be based on medical necessity. These protocols impact all services approved through the HCBS Medicaid waivers: the Arlington Waiver, the Statewide waiver and the Self Determination waiver. They can change frequently and it is strongly recommended that you review the listing of the protocols at http://www.state.tn.us/dmrs/provider_agencies/Protocols.html

The Protocols were implemented effective August 1, 2008 as Individual Support Plans (ISPs) are renewed or amended. The protocols on physical therapy, occupational therapy, speech and language, nursing and nutrition services took effect before August 1, 2008.

Approval of all requests for services will be based on “medical necessity.” Medical Necessity questions are included in each Protocol. There must be sufficient information in the ISP or additional supplementary documentation to justify the approval of the services that are being requested.

The questions below are adapted from the medical necessity questions included in the Protocols.

- Is there sufficient evidence in the ISP that the service recipient requires or continues to need the identified service?
- Is there sufficient evidence in the ISP that the service recipient’s needs cannot be met without the service?
- Is there sufficient information to demonstrate that progress can be made in terms of measurable functional gains?

- Are there clearly defined measurable goals based on the person's current age and health status?
- Is the requested service the least costly adequate option?

One-person homes will only be approved for individuals with significant psychiatric or behavioral challenges. Companion-model one-person homes will be approved if they are more cost-effective than serving the person in a two-person home.

All services for children 20 years of age and younger will be Transitioned to TennCare Managed Care Contractor (MCC) the TennCare program for children.

There will be limits on amount of service approved. Services that are approved must be consistent with and not in excess of enrollee's needs.

Appeal process: If the requested service is denied or reduced, you can file an appeal within 30 days from the date of the notice. If the appeal is received within 10 days, the service will be continued until the appeal is resolved. If no request to continue services is received by the 30th day, the services will be discontinued on the 31st day, or on the date specified in your Letter of Denial.

Protocols: The Protocols are posted on the DMRS website at: http://www.state.tn.us/dmrs/provider_agencies/Protocols.html. Also listed are the Protocols Checklists that are being used by the Plans Reviewers to review all requests for services, including ISP renewals and requests to additional services. The Checklists are posted at: http://www.state.tn.us/dmrs/provider_agencies/ProtocolsChecklists.html. To see a list of the protocols in Word developed by The Arc of Tennessee with a brief description of each one go to http://www.thearctn.org/Assets/docs/DMRS_Protocols_092208.doc.

NOTE: YOU MUST FILE AN APPEAL WITHIN 10 DAYS OF WHEN THE LETTER OF DENIAL OR CHANGE OF SERVICES WAS SENT IN ORDER TO CONTINUE RECEIVING SERVICES WHILE YOUR APPEAL IS BEING HEARD.

This website includes information on how to submit an appeal and a place for you to tell your story so that The Arc will be able to share with legislators how these cuts are impacting you.

Inventory of Client and Agency Program (ICAP) Assessment

The ICAP will be done about three months before the person's ISP is due. The ICAP is being done by an independent agency (group). The person administering the ICAP usually wants to talk primarily to the key support staff and often ask other agency personnel to leave the room. Family members should alert the provider and ISC that they demand to be present when the ICAP is being administered. After the first one, a new ICAP will be done whenever the person's needs change, or at least every other year. They are being completed on many people during 2008 and 2009

- Information for the ICAP comes from the person, family members, conservator, or others who know the person very well.
- The ICAP helps to identify what kinds of services the person may need, activities the person may need help with, and other assessments that should be done.

After the ICAP is completed, the person and his family or conservator meet with the ISC to develop outcomes the person wants in the ISP.

- They will also identify things that are necessary to be healthy and safe.
- Things in the ICAP that you feel are incorrect, can be discussed at this meeting.

NOTE: It is strongly recommended that you become familiar with you family member's ICAP Assessment Score. This can be accomplished by talking to your Independent Support Coordinator (ISC) or your service provider. Ask them what the score is and then ask to be alerted if they are contacted when a new ICAP will be done. You should then tell them that you want to be present when the assessment is administered.

Once completed ask that you be notified of the new score and if possible a copy of the assessment. If the score is lower than in the past you should ask for a review of the results and to be informed of the changes that caused the lowering (change in) of the score.

Formal Appeal Notice

When your family member's Individual Support Plan (ISP) has been reviewed and a decision to reduce or eliminate a service is made, DMRS will send a letter either to the person or their legal representative (conservator) and the Independent Support Coordinator (ISC). This letter will state the intent to reduce or eliminate a service. It is very important for you as a family member to alert your ISC, the Service Provider, and the staff at your family member's home that you want to be informed immediately if a service is going to be reduced or eliminated. You must review the service reduction and make a decision if this reduction will have a negative effect on the supports that are currently being received.

The Arc of Tennessee has advocated for individuals and families to be involved in the cost plan review process but to date has had no success in having this included. DMRS is meeting with provider agencies in Middle Tennessee and most likely will be doing the same in East and West soon. The purpose of these meetings is to review the services a person is receiving and determine if a person can do with out a service, a reduction in the frequency of the service, or if living alone, could live with someone else (either in the home they currently live or to move to another home of another person receiving services.)

If your family member receives a letter stating that services are going to be eliminated or reduced you will have **only 10 days to file an Appeal** of this decision and keep services in place until the appeal is heard. While you do have up to 30 days to actually file the appeal, after the 10 days your family member's will be terminated while you are waiting for the appeal hearing. You can download an appeal form from TennCare's website:

www.state.tn.us/tenncare/members/medappeal_form.pdf

You will not receive a notice when the rates are reduced. It will be up to you and your family member's Circle of Support to determine if the reduction has reduced the intensity (such as the staffing utilized in a residential service), the frequency (such as how often a person may receive Occupational Therapy), or duration (such as limiting the time frame that Speech Therapy may be authorized to only 90 days.)

Should you and your family members Circle of Support determine that the intensity, frequency, or duration will adversely affect their health and well being an **Appeal should be filed within 10 days so as to keep the service in place!** You can download an appeal form from TennCare's website: www.state.tn.us/tenncare/members/medappeal_form.pdf

Bullet points on how to Appeal

- An appeal may be filed if a person's Medicaid Waiver services have been denied, terminated, reduced, delayed or are not being provided as needed. Anyone may submit an appeal on the person's behalf. You do not have to use this form to file an appeal. You may make your appeal in a letter or you may call in your appeal. The appeal must be made within **30 days** of the date of the adverse action notice (letter) from the Division of Mental Retardation Services (DMRS).
- Question #1 - Complete this section.
- Question #2 - This is the person that DMRS or TennCare should call for more information. Leave blank if same as the person submitting the appeal.
- Question #3 - The appeal must be submitted no later than 10 days from the date of the notice to ensure continuation of the service during appeal.
- Fill out Part B on Page 2
- Question #4 - **DO NOT MARK** the box for an EMERGENCY APPEAL.
- Question #5 - This is the person that the DMRS or TennCare should call for more information. Leave blank if same as the person submitting the appeal.
- Question #6 - If desired, you may state below the reasons for this appeal OR attach additional information. However, you may leave this section blank if you wish. You are not required to provide any additional information at the time that you file the appeal. You will have a chance to provide more information about your appeal to the DMRS or TennCare after you file the appeal. Someone may call and ask you for more information about your appeal. If there is a hearing about your appeal, someone will contact you to schedule the hearing. During the hearing, you will have an opportunity to tell your reasons to administrative law judge.
- **How to File Your Medical Appeal** - You may fax, mail or call-in your appeal. The appeal goes to the Bureau of TennCare's Solutions Unit. TennCare Solutions handles all Medicaid Waiver and TennCare appeals. You may also send a copy to the Regional Office of the Division of Mental Retardation Services. Keep a copy of your appeal and a record of when you submitted the appeal.

Fax TennCare:

1 – 888 – 345 – 5575

(Toll Free)

Mail:

**TennCare Solutions
P.O. Box 000593
Nashville, TN 37203 – 0593**

Call TennCare:

**1 – 800 – 878 – 3192
(Toll Free)**

DMRS Regional Office Fax Numbers:**West**

Attention: CJ McMorran
901-867-7809

Middle

Attention: Kathleen Clinton
615-231-5150

East

Attention: John Craven
865-594-5180

Reduction of Payment to Providers

DMRS is again considering this action sometime in October, 2008. While the actual percentage of reduction has yet to be determined, when it does happen this will mean addition reductions in services by providers such as staffing reductions, limits on travel for community involvement, or limits by therapy service providers such as the distance they will travel to and from the person's home.

This action was implemented from January through April of 2008. All providers in the Statewide Waiver had their payments reduced by 6.1%. Basically what happens is the Division has a set of listed rates they pay for each service based on the persons Level of Need. When the provider invoices for services provided, they utilize these rates. When DMRS receives the invoices they pay the provider. In this case they reduce the payments to the providers by a predetermined percentage.

NOTE: The effect of the payment reductions can affect the intensity, duration and frequency of the services provided to your family member. If this occurs and the services are not what your family member needs then you should immediately file an appeal as described on this Website!

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Submit your stories

The Arc of Tennessee is asking you to submit information about your family member and you and the effects that either the Funding Rate Reduction or the Cost Plan Review (and ultimate reduction or elimination of a service) has had on your family member receiving Medicaid Waiver funded services. It will be utilized to track what is happening to people as a result of the actions by DMRS. If you provide us with permission to do so we will post this information on our website without identifying information. We will tally all information and provide the information to legislators and the administrators of the Division of Mental Retardation Services when advocating for change in the process of reducing costs of services.

If you would like to share your story, email it to cuts@thearctn.org. Please provide:

- the name of your family member
- your name
- contact information including the county your family member lives
- the agency providing the supports to your family member
- the reduction or elimination of a service
- the effect that this has had on your family member's quality of services being provided to them
- whether or not you give us permission to post your story on our website