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I. PAYMENT REIMBURSEMENT METHODS

The provider has available two methods for reimbursement for services rendered, Regular Payment or Ready Payment. The provider has the right to request the Ready Payment option; however, DDS staff reserves the right to make the final decision. The Ready Payment option is available for both unit rate and cost reimbursement programs.

A. REGULAR PAYMENT – In the Regular Payment methodology the provider submits a standard invoice with any required documentation at the conclusion of each month.

B. READY PAYMENT - This system allows providers to choose a reimbursement system that provides periodic automatic payments, in amounts up to 1/24 of contracted maximum obligation levels that are later reconciled to actual contract billings. These periodic payments, which begin during the middle of July, smooth the reimbursement process and provide “bridge” funding at the beginning of a new fiscal year.

C. UTILIZATION FACTORS

1. Residential Service contracts (Chapter 257 rates) will be reimbursed using a 95% utilization factor.
2. Day/Employment Services contracts (Chapter 257 rates) will be reimbursed using an 87% utilization factor.
3. Non-Regulated Unit Rate contracts will be reimbursed using an 85% or higher utilization factor.
4. ABI service contracts do not have a utilization factor.

NOTE: FOR FY2017 THE READY PAYMENT AMOUNT WILL BE ADJUSTED TO A MAXIMUM OF 80% OF THE 1/24 VALUE IN ORDER TO REDUCE THE INCIDENTS OF OVERPAYMENT.

The Ready Payment system, which is administered by the Office of the Comptroller, will continue to serve DDS’s contracted providers.

The Ready Payment methodology provides for an automatic check to be sent to the provider on a prescribed schedule with a reconciliation invoice required from the provider at the end of the month. DDS contracts typically use the Ready Payment schedule listed below:

- **Semi-Monthly** – The semi-monthly methodology provides that automatic checks are sent to the provider approximately twice a month with a maximum base payment of **80% of 1/24th** of the document total.

Process – the Ready Payment methodology will issue the first automatic check at approximately the second week in July (for July 1st start contracts.) The final check issuance will vary based upon the level of spending versus the maximum

obligation. Therefore, it is possible that the last check may be issued prior to the end of the fiscal year.

CAUTION: DDS has the right to remove a provider from the Ready Payment method (for procedural reasons) if there is insufficient billing by the provider as demonstrated on the reconciliation payment vouchers.

II. SERVICE DELIVERY REPORT (SDR) REPORTING INSTRUCTIONS FOR PROVIDERS

<http://www.mass.gov/eohhs/provider/contracting/doing-business/dds-pos/pos-contracts/>

Once this site is located enter “POS” in the search box, click, then click on “POS-Contract Forms”.

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|--|
| <p style="text-align: center;">Department of Developmental Services SERVICE DELIVERY REPORT (SDR)</p> |
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Required Submission:

A *Service Delivery Report* (SDR) must be submitted with a Payment Voucher (PV) at the end of each billing period, in order to process payment for unit rate and cost reimbursement contracts. *Service Delivery Reports* are due to the purchasing agency no later than the 10th day of the month (or 7th working day) for Ready Payment Contracts. Cost Reimbursement Contracts must also submit a Monthly Expenditure Report (MER) along with an SDR.

Please Note: The “Utilization Factor” incorporated into many Unit Rate Contracts causes some contracts to bill out before the fiscal year ends. DDS requires that SDR’s still be submitted for the remaining billing periods, documenting all consumer attendance or services rendered through June 30, the end of the fiscal year.

III. DDS APPROVED ABSENCE POLICY—RESIDENTIAL PROGRAMS

At any given time in a residential program there is the potential for one or more consumers to be absent from the program. This absence can be of either a short term or a long term nature. When it becomes apparent to a provider that such absences will exceed the number of days reimbursed by virtue of the utilization factor built into the unit rate the provider may consult with the Area Director to determine the best form of action that will allow the provider to be properly reimbursed for staffing and other resources provided during the period of the absence. Such action may occur in one of two ways, or in a combination of the two. The available options are: 1. Program Model Change; and 2. Approved Absence Policy (AAP). The unique circumstances relating to the accumulated absences may help determine which option or combination of options is best suited to the program.

I. Program Model Change

When an absence from a program on the part of one or more individuals is likely to be long term in nature so that the staffing structure of the program can reasonably be adjusted to the revised lower capacity level, a modification to change the program capacity and the program model might be the most accurate method of adjusting to the change. If and when the consumer(s) return to the program a subsequent modification can be processed to change the capacity and model a second time.

II. Approved Absence Policy

When absences are of a short term nature and the capacity of the program is not changing in response to these absences, the program model change may not be the best option. In these situations the provider may choose to request the application of the Approved Absence Policy.

Permission to bill for absence days must be applied for by submitting to DDS the attached Billable Absence Request Form and Absence Policy Worksheet. These forms are to be submitted to the Area Director who manages the contract in question. Submissions should only occur once the Absence Policy Worksheet demonstrates that available units of service covered by the Utilization Factor have been exhausted. Once this has been demonstrated, the provider must indicate on the Billable Absence Request Form the specific individuals and dates for which they will attribute billable absence units.

The Area Director's signature approval may authorize the billing of any absences in excess of the utilization factor *so long as there are no individuals enrolled in the program who have been absent for more than 60 consecutive days*. Any individual who has been absent for more than 60 consecutive days must be reported in Section II of the Billable Absence Request Form, and requires that the Regional Director authorize the request.

Subsequent requests for additional billable absence units require the submission of an updated Worksheet and new Billable Absence Request/Approval Form. The deadline for submitting requests under the Approved Absence Policy is 15 days after the close of the fiscal year. In no case shall billing under this policy be permitted beyond the total number of billable days available to the program.

When absence units are requested for an individual, Billable Absence Request Forms need to be submitted to the Area Director who oversees service coordination for that individual. In cases where contracts contain individuals originating from multiple Area Offices, the provider must submit separate requests to each Area Office specific to the individuals they oversee.

Requests for billable absence units should be targeted at those absences which have occurred most recently in the program. When at all possible, absence units should only be

awarded in the most recent billing month so as to reduce the need for supplemental billing.

No absence from a Residential program will be reimbursed to the provider except in the specific situations listed below.

A. Absences Due to Illness

In cases in which program absences occur because of illness and available units of service under the Utilization Factor have been exhausted, the Area Director may approve the absence for reimbursement. *Any individual who has been absent for more than 60 consecutive days during the fiscal year must be reported in Section II of the Billable Absence Request Form.*

After 60 consecutive days' absence on the part of an individual, a decision must be made as to the advisability of continuing a particular individual in the program. If the Area Director supports the rare instance in which an individual should remain in the program after a period of 60 days absence the Area Director may request approval from the Regional Director for continued placement and absence reimbursement for a period of time as determined by the Regional Director to be necessary and appropriate.

B. Known/Recurring Absences

Residential contract rates are developed with a utilization factor that allows for planned routine absences (e.g. weekends home, vacation time, etc.). In cases in which an individual is expected to be out of a given residential program for planned, routine absences, such as family visits, and units available to cover absences under the Utilization Factor have been exhausted, the Area Director may approve billing for such planned absences. Once approved, billing will be allowed as if the individual were present and served. Relevant data and justification referring to the Known/Recurring Absence must accompany the Billable Absence Request Form.

Please Note: In rare cases where Known/Recurring absences are predictable, the rate model and number of units can be selected in advance to create a blended rate that adjusts program staffing and other resource levels during the planned absence period and at the same time fairly compensates the provider. When this has been done, these recurring absences shall **not** count toward the application of AAP. Only absences not considered in the selection of the program model shall be considered eligible for Approved Absence consideration. Providers who believe that they operate a program where this option is preferable should contact DDS staff to assess the feasibility of using this option.

III. Vacancies

The approved absence policy is not a vehicle for funding vacancies. In situations where a vacancy in the program exists, the site containing the vacant bed must be re-slotted to a

lower capacity model before calculations regarding the exhaustion of utilization factor units occur. This applies to situations where there is a vacancy without an enrollment, and to those situations where the Area Director determines that it is no longer advisable to maintain an individual's enrollment due to long-term illness or extended absence from the program.

IV. Combination of Program Model Change and AAP

In some circumstances it may be advisable to use a combination of the two options. For example, a series of short term illnesses or other recurring absences may have grown so that the provider has exceeded the number of Utilization Factor units whereby the provider has been granted AAP units. Later an individual is required to leave the program permanently or for a long term. Such a situation may require a program model change at that time.

V. Absence Policy Worksheet

A form has been made available for providers to track the usage of units reimbursed by means of the utilization factor. This form calculates the number of remaining units paid for by the utilization factor based on program capacity and year-to-date billing. When this form shows that all utilization factor units have been exhausted, the provider may then submit a request for billable absence units. Submission of the completed worksheet is required for all approved absence policy requests.

*NOTE: This policy covers services contracted under DDS activity codes 3153 – Adult Long Term Residential Services and 3150 – Placement Services. This policy **does not** apply to ABI residential services under codes 3751 and 3752.*

BILLABLE ABSENCE REQUEST FORM—RESIDENTIAL PROGRAMS

| | | | |
|-------------------|--|------------------|--|
| Provider Agency: | | Submission Date: | |
| Provider Contact: | | | |
| Contract ID: | | Fiscal Year: | |

I. Absence Policy Qualification Status:

Additional documentation demonstrating exhaustion of Utilization Factor days attached

No absences shall be authorized for billing until all days available under applicable Utilization Factor have been exhausted.

II. Long Term Absences:

Has any individual in this contract been absent 60+ consecutive days (Y/N)?

| Name of Individual | Days Absent | Description |
|--------------------|-------------|-------------|
| | | |
| | | |
| | | |
| | | |

III. Absence Policy Billing Authorization:

TOTAL number of absence days requested

In the table below indicate all individuals for which billable absence days are being requested (first name and last initial only), the date range in which billable absence days will be applied, the maximum number of billable absence days to be authorized for each individual, and a brief description of the reason for absences (ex: illness, planned absence, etc.).

NOTE: If this table does not provide sufficient space, please submit a complete listing as an attachment to this form.

| Name of Individual | Billable Date Range | Max. Billable Days | Description |
|--------------------|---------------------|--------------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |

Absence days may only be billed in accordance with the maximum number of days indicated for each individual named above, and may not be transferred between individuals to meet the total number indicated above.

| | | | |
|---|--|-------|--|
| Area/Regional Director Signature: | | Date: | |
|---|--|-------|--|

Request Rejected

IV. DDS APPROVED ABSENCE POLICY—NON-RESIDENTIAL PROGRAMS

If an individual is absent from a non-residential program because of illness beyond two weeks of regular authorized hours, the Area Director may authorize reimbursement for certain periods. An Area Director's signature/approval permits the Service Provider to bill from the third and fourth week absent from non-residential programs. Allowable billing must be based on the regular weekly level authorized for the individual. If the absence continues beyond four weeks, both the Area Director's and Regional Director's signatures/approvals are necessary for the Service Provider to bill for further reimbursement. The dual approval covers billing up to eight weeks of absence from a non-residential program.

After eight weeks absent from a non-residential program, a decision must be made as to the advisability of continuing the individual in the program. In no case may reimbursement continue after the eighth consecutive week. All other sick days are not billable, and must be assumed under the Utilization Factor.

In the case of non-residential programs, the decision to permit billing for absences may consider limiting approved allowable billing to absences that will not exceed the applicable utilization factor used to establish the billing rate.

V. DDS APPROVED ABSENCE POLICY—ABI PROGRAMS

ABI services fall under the authority of Mass. Health regulations. Mass. Health regulations contain no provisions for reimbursing absences. Therefore, any absences in ABI programs are not reimbursable.

VI. ENTERPRISE INVOICE MANAGEMENT (EIM)

Enterprise Invoice Management/Enterprise System Management (EIM/ESM) is a web-based billing and service delivery reporting system for Purchase of Service (POS) providers and is one of the many services offered through the EOHHS Virtual Gateway. All POS providers doing business with DDS must use EIM for service delivery reports and invoicing.

Provider organizations that are new to EIM will be contacted by EIM representatives for training and setup. New providers that have not heard from an EIM representative should contact their DDS Regional Contract Manager. Additional training is available to providers as needed. Further information is available at www.mass.gov/vg/eimesm .