



M. Jodi Rell
Governor

State of Connecticut
Department of Developmental Services

DDS

Peter H. O'Meara
Commissioner

Kathryn du Pree
Deputy Commissioner

Memorandum

TO: Alyssa Goduti
CCPA

FROM: Joe Drexler
Director of the Operations Center

DATE: February 11, 2009

SUBJECT: *Revised Budget Reductions*

Thank you for sending me CCPA's comments on the DDS Draft Contract for Residential and Day Services dated 1/9/09.

As you know, sections three and four of the DDS contract have not been changed substantially for a number of years. The upcoming transition to a Fee for Service reimbursement system required numerous changes and revisions to the contract, as well as, updating the verbiage to more respectful language. The Department has reviewed CCPA's comments and has incorporated some of them into the contract revisions. I have highlighted the sections that have been modified and remarked on those that the Department did not accept.

Part III.

- Reports Required - Section 2c – We suggest changing the requirement for contractors to submit attendance reports from the 5th day of the month to the 10th day of the month. This would allow time for the contract to review and process attendance information.

This is the language in the existing contract. The current contract language states that the providers must submit attendance on the 5th of the month. The issue centers around the fact that the Waiver Billing Unit uploads the attendance from the Web-based attendance program on the 10th of the month for Medicaid Billing. The advent of the new web-based program in which program site supervisors have continuous access to the attendance forms should decrease the time to complete the attendance. In addition, administrators who have the authority to approve the submittal of the agency's attendance no longer need to wait to review the paper copy. Since provider reimbursement will be based on the attendance submitted, the narrow time between the submission of the attendance and the uploading by the Waiver Unit is needed for the Resource Manager and provider to solve any coding or ECAMRIS problems.

Phone: 860 418-6000 ♦ TDD 860 418-6079 ♦ Fax: 860 418-6001
460 Capitol Avenue ♦ Hartford, Connecticut 06106
www.ct.gov/dds ♦ e-mail: ddsct.co@ct.gov
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<p>Distributed by: CCPA 35 Cold Springs Road, Suite 522 Rocky Hill, CT 06067</p>

While the Department understands that this may be a tight timeframe, the Operations Center will do its best to work with those providers who are having difficulty submitting the attendance to come up with a mutually acceptable solution.

- Annual Audits – Section 4 – We recommend including “The Commissioner or his/her designee will respond within 7 days to a provider request for a waiver of penalty fees.”

The contract has been revised to state, “The Commissioner or designee will respond within 14 days to a provider request for a waiver of penalty fees.”

- Payments – Section 6 – Draft language reads that “ Day programs will be reimbursed based on the monthly client attendance at the established rate ...” We continue to raised concerns about the financial hardships this new attendance-based reimbursement system has on providers. We encourage the Department to adopt an attendance factor that more accurately reflects historical attendance rates in the DDS system. We also urge the Department to develop rates that meet the true costs of providing services. I’ve copied a letter from the members of the Provider Council to Commissioner O’Meara dated September 29, 2008, which describes provider concerns about the current attendance rates being considered by DDS. We ask that the Department review the base rates and attendance data to develop a system that meets costs of services.

This issue has been addressed by the Commissioner in a letter dated 10/31/2008 in reply to the Provider Council. As was stated in the letter “The transition to an attendance based reimbursement system has been part of the transition plan since 2006. All providers have been informed of this transition and the move should not be seen as being expedient. We recognize that not all providers will initially meet the 90% factor. It should be noted that the 90% factor is after 10 holidays for a real factor of 86.5%. Providers should have been planning for this system change and begun to implement transitional strategies to reduce costs or increase revenue to make up some of the shortfall. Using the 90% factor, the state shares the financial burden but does not exclusively own it. It is reasonable to expect that a provider who has 80% attendance should be able to operate spending less money than a provider who has 90% attendance.

Part IV

- A6 – Draft contract language reads “No person will be discharged or suspended from a program without the review of an IDT meeting and the approval of the Region Resource Administration.” We ask that the department change this language to allow a provider to make determinations about who they are able to continue to serve based on the individual situation. Providers need to have the ability to stop serving an individual if circumstances in the person’s health or behaviors change in a way that the contract does not cover the costs of providing the services necessary to assure health and safety of that individual and others in the program.

This is the language in the existing contract. The Department believes that it would not be in the best interest of the individuals it serves to delete this provision. It would be detrimental to the individual to be left without a program with very little warning. There are sufficient safeguards that have been put in place to address the concerns of the provider. DDS continuously collaborates with providers to ensure the supports and funding are appropriate to the individuals served by the Department. Individuals who are in need of additional funding are referred to the regional Placement and Resource Allocation Team (PRAT). Additional resources are funded through an increase in the annual allocation or one-time funding process. In addition, the regional resource administration works cooperatively with providers on issues that affect the agency and/or the individual.

- Day Programs – Section 3 – We have serious concerns about the proposed change in minimum day program hours from five to six hours. For many providers this imposes a significant additional cost without additional resources to cover those services. We ask that DDS reevaluates this change as it is an unfunded mandate on providers.

The contract revision increases the number or hours a group day program is open from five hours excluding lunch to a six hour program including lunch. If you estimate that an average lunch is at least 30 minutes, the increase is actually half an hour or less. In addition, the draft day rates that have been presented to the Provider Council and the Waiver Work group are based on an hourly rate multiplied by six hours. It is the Department's position that the increase to a six hour program is not an unfunded mandate. However, language has been added to address those low rate providers who may need time to increase to the new standard day. The revision is as follows: "Contractors with an agency rate below the established Fee for Service rate and provide less than 6 hours/day, five days/week will increase the programming hours to the standard rate in accordance with the transition plan developed to increase to the established rates."

- Day Programs – Section 4 –We also have serious concerns about the implication of changing the minimum days a program is open from 245 days/year to 250 days/year. Similar to the comments above, this imposes a significant unfunded mandate on many providers contracting with DDS.

It is the Department's position that the increase to a 250 day standard is in the best interest of the provider. The established Fee For Service Rates are based on 90% attendance to a standard 250 days. In other words, a provider will receive 100% of an individual's funding if the participant attends the program 225 days. For every day the individual attends the program above 225 days, the provider will be reimbursed an additional day of funding up to the standard 250 days. Providers should understand that the greater the number of days the program is open the more opportunities they will have to maximize their revenue. However, contract language was kept to allow providers to receive approval by the regions to operate less than

the 250 days. Additional contract language was added to clarify that the rates would not be adjusted for those programs operating less than the standard number of days.

- Day Programs – Section 7 – We ask that the department examine the process of adjusting services and resources and/or moving a participant from one model to another. We’ve had discussions over the past several years about the timeliness of the PRAT process, the ability for the PRAT team to make quick and appropriate decisions an the available resources to make permanent changes in an individual’s plan. As a result, the use of one-time funding has increased substantially over the past several years. We ask that the Department develop an alternate process for addressing emergencies that require enhanced service plans so that providers aren’t forced to provide additional services without a guarantee that those services will be reimbursed.

The contract states what is the current process. This is an issue that should be addressed through the Provider Council.

- Part IV Section E – Part f – Community Living Arrangements – Draft language states “Maintaining an environment that results in a healthy, clean well dressed and well groomed appearance of the people living in the home.” We suggest amending the language that references “well groomed” to focus on client health, safety and quality of life.

The contract has been amended to read: Providing supports to individuals that allow people to be clean, well dressed, well groomed and live a healthy lifestyle.

- Part IV Section E – Part g – We suggest amending the timeline to allow for individual plan documentation within 45 days of the meetings.

This section refers to the timelines listed on the Guide to Individual Planning on the web http://www.ct.gov/dds/lib/dds/forms/ip/ip_guide.pdf (page 7). The Guide is in the process of being revised. This would be a good time to address your concerns regarding the timelines. The contract language has been revised accordingly “Forwarding Individual Plan and required documentation in a timely manner to case managers and others in accordance with the Individual Plan procedures.”

- Section F – Part d – Emergency Situations – We ask that the Department develop a plan to assist providers in covering the costs of these emergency situations in a timely manner. Draft contract language states “The IDT will convene, as soon as possible to review the incident and adjust the support plan as needed.”

Enhanced service plans are addressed within the IP and PRAT process.

Distributed by:
CCPA
35 Cold Springs Road, Suite 522
Rocky Hill, CT 06067

cc: Peter H. O'Meara, Commissioner, DDS
Kathryn du Pree, Deputy Commissioner, DDS
Peter Mason, Operations Manager
Terry Edelstein
Martin Schwartz
Patrick Johnson
Thomas Sullivan
Pam Fields