

1/26/08

To: Joe Drexler, Operations Center Director, DDS

From: Alyssa Goduti, Vice President for Public Policy, CCPA

RE: CCPA Comments on DDS Draft Contract Changes – 1/9/09

Thank you for the opportunity to comment on the DDS Draft Contract for Residential and Day Services dated 1/9/09. I've organized comments and recommendations on the draft contract from CCPA members below. We hope you will consider our concerns and recommendations as you move forward in implementing a revised contract. We look forward to an opportunity to talk with you about these suggestions.

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.
- 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.”
- 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.

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.
- 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.

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

Please feel free to contact me at agoduti@ccpa-inc.org or at (860) 257-7909 with any questions.

Alyssa Goduti

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September 29, 2008

Peter O'Meara, Commissioner
Department of Developmental Services
460 Capitol Ave.
Hartford, CT 06106

RE: Concerns from the Provider Council – Transitioning to an Attendance-Based Fee-for-Service Reimbursement Structure

Dear Commissioner O'Meara:

Provider members of the DDS / Private Provider Council seek your help to address concerns over the transition plan to move from rates set in a master contract to an attendance-based fee-for-service reimbursement structure. If this shift moves forward as presented by DDS at the September 12, 2008 Provider Council meeting, there will be a serious impact on the health and stability of the provider system. Ultimately it will impact aging and medically frail individuals with developmental disabilities who will struggle to find providers to take them on as clients. In this challenging economic time, when providers are struggling to survive with a 0% funding adjustment to cover their growing costs of services, changing a reimbursement structure in a manner that further reduces provider funding would create extreme hardships.

Our specific issues include:

1. Reasonableness of 90% Attendance Expectation for DDS Clients

- Basing the rates on 90% attendance is unreasonable given the medical, physical and personal needs of DDS clients. This shift penalizes providers who serve consumers with generally lower attendance, which are typically older or more medically frail individuals. It creates a disincentive for providers to take on new consumers that are elderly or have significant health or behavior issues. Even state employee contracts assume an 85% attendance factor including holiday, sick, vacation and personal time.
- Where did the 90% attendance factor originate?
 1. We ask that you provide us documentation of utilization rates billed to CMS for both public and private sector day and residential programs for the two most recent years of complete data.
 2. We also ask for summary reports of public and private sector client attendance records for the two most recent years of complete data to validate the use of 90% as a baseline.
- DDS staff has encouraged providers to better manage vacancies by overbooking and calling in substitutes when needed. This was recommended again at the September 12, 2008 Provider Council meeting. Overbooking could lead to staff ratios that are not appropriate to meet licensing and quality assurance standards and more importantly could put client health and safety at risk. With turnover

rates at nearly 25% annually and direct care salaries that are comparable to fast food restaurants, it is difficult to hire regular staff, let alone maintain a pool of substitute staff.

- This new payment system contradicts the philosophy of normalization for DDS clients because it discourages them from taking family vacations, traveling and taking personal time off from their day or employment programs. Under this model, providers will have to discourage such valuable time off. If this is the position of the Department, then we ask that DDS communicate officially with families about that change.

2. Implementation Timeline / Process Concerns

- The current plan to implement an attendance factor for 50% of provider payments does not allow for a pilot examination of the impact of this change. Initially DDS had proposed a six month tracking of attendance without impacting rates. This would have allowed for thorough examination of the impact and would help to validate the use of 90% as a reasonable attendance factor.
- The decisions to move forward with implementation of attendance-based reimbursement as of January 1, 2009 did not provide for proper discussion and feedback from the Provider Council's Waiver Workgroup. The Waiver Workgroup members were asked to gather feedback from each of their trade associations about this new plan. However, the next scheduled meeting of the Waiver Workgroup was canceled by DDS and was not rescheduled prior to the full Provider Council meeting. Waiver Workgroup members were never given a forum to provide feedback before DDS presented their decision to the full Provider Council.

We ask that you consider our concerns and delay implementation of the attendance-based reimbursement system until these concerns can be addressed. We hope to work together in partnership moving forward to create the best system of care for the individuals we serve. We appreciate your help in addressing these important concerns and look forward to your response.

Sincerely,

Alyssa Goduti
Vice President for Public Policy, CCPA

Julia Wilcox
Public Policy Specialist, CT Nonprofits

Provider Council Members (list names, titles, organizations)

CC: Secretary Robert Genuario, OPM

Kathryn duPree, Deputy Commissioner, DDS
Senator Handley, Co-Chair, Public Health Committee
Representative Sayers, Co-Chair, Public Health Committee
Senator Jonathan Harris, Co-Chair, Human Services Committee
Representative Peter Villano, Co-Chair, Human Services Committee
Joe Drexler, Director, Operations Center, DDS
Peter Mason, Operations Manager, DDS
Mary McKay, Regional Director
Fritz Gorst, Regional Director
John Houchin, Regional Director
Council on Developmental Disabilities