ADDP Association of Developmental Disabilities Providers

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December 30, 2015

Secretary Marylou Sudders
Executive Office of Health and Human Services (EOHHS)
One Ashburton Place, Room 1109
Boston, MA 02108

Re: 101 CMR 415.00: Rates for Community-Based Day Support Services

Dear Secretary Sudders and officials of EOHHS,

Thank you very much for taking the time to consider our comments regarding your proposed regulations for rates for Community-Based Day Support Services, 101 CMR 415.00. As you may already know, ADDP represents 130 human service providers who provide services for individuals with developmental disabilities and acquired brain injuries. ADDP is very appreciative of the cost-adjustment-factor (CAF) of 2.05% that is being applied in accordance with the Chapter 257 Settlement Agreement. However, ADDP providers have expressed that these rates need to be reviewed to provide an increase that accurately reflects the actual current costs and the projected costs of providing these Community-Based Day Support Services: DDS Activity Codes: 3163, Community Based Day Supports (CBDS) and 3166, Blanket Day Services. We appreciate your consideration of our collective concerns to establish new rates in such a manner that (a) providers may achieve the goals set forth in CMS's Final Rule in concert with Olmstead Compliance and (b) where there are not unintended consequences that place a burden on human service providers who serve for aforementioned population.

We understand that the CAF factor is a part of the legal settlement involved with Chapter 257, but if the CAF Factor cannot be reviewed, then we strongly ask that a full rate review be done as soon as possible due to the mandated changes that have been required of these activity codes, changes which are not accounted for by the review of 2014 financial data.

<u>Role of Community Based Day Support Services (CBDS):</u>

CBDS is designed to enable individuals to enrich their lives and enjoy a full range of community activities by providing opportunities for developing, enhancing, and maintaining competency in

personal, social, and community activities. Some services include career exploration, community integration, skill development and training, development of activities of daily living and independent living skills, support to enhance interpersonal skills, and pursuit of personal interests. CBDS is intended for individuals of working age, a supplemental service for those who are employed part-time needing a structured and supervised program of services during the day when they are not working, and those of retirement age needing to participate in a structured and supervised program of services that now under new CMS guidelines must occur in integrated community settings. Under the new CMS guidelines, the Massachusetts Blueprint for Success, and the Massachusetts plan for meeting the new CMS guidelines, CBDS has become an important and vital instrument in the success of these plans. These plans have required significant changes to CBDS to comply with CMS regulations since June 2014 when the program was reviewed for the CAF factor involved in these plans. In addition to these elements being monitored by CMS regarding the Department of Developmental Services' (DDS) transition plan, the Department of Justice (DOJ) and the Department of Labor (DOL) have also been heavily involved in monitoring compliance with Olmstead and the Americans with Disabilities Act (ADA) to ensure that full community integration is occurring throughout the nation. There have been a series of lawsuits pursued by these entities in various states where they have found states were not providing community integration to the fullest extent possible. CBDS is a key component in complying with Olmstead and the ADA and these services need to be made available to the fullest extent possible to ensure compliance.

CBDS is now going to be considered ***the*** essential tool to ensure that all people interested in non-medical based day programs, either part-time or full-time, have a program that will ensure an active, educational, and instructional program that has activity based in participants' local communities at least 50% of the time. This change requires greater staff to consumer staffing ratios, thus causing a significant increase in hiring, training, and supervision of staff. These factors are not included in the current CBDS rates, nor are they included in the CAF factor calculation process.

History and rate analysis

ADDP providers are concerned that the current regulations only address the CAF adjustment from Chapter 257 and do not address a significant need of rate adjustments that take into account the considerable degree of change that programs are in the process of undertaking. For example, providers are implementing mandated closure of sheltered workshops, shifting services to integrated community settings. This alone causes for an increased need for more staff to achieve ratios necessary across the service spectrum due to the CMS rule.

As of October 2015, the number of individuals receiving CBDS services more than doubled to 5,422 compared to 2,656 individuals in June of 2013. Out of the 5,422 individuals most recently reported receiving CBDS services, approximately 3,000 of these individuals are not receiving any other DDS funded employment service. The increase directly relates to closure of sheltered workshops (one goal of the Massachusetts Employment Blueprint). Most individuals who transitioned out of sheltered workshops went into CBDS as a pathway to employment.

It is important to note that staff-to-client ratios differ in CBDS model in comparison to sheltered workshops. For instance, in CBDS staff ratios are currently built based on the intensity of clinical needs and do not factor in the requirement to provide services in ***integrated community settings based on person-centered planning.*** Providers are currently transitioning from a model of service in sheltered work, where it is common to have one staff work with anywhere from 15 to 20 participants at a time. This staffing pattern is not possible in CBDS. It is not possible because the needs of the individuals require a ratio on average of 1:3 to 1:4 in order to provide a quality community-based program. It is also not possible due to the new CMS regulations. For instance, a ratio higher than 1:3 to 1:5 will not be allowed and will not be supported by CMS. Furthermore, in order to achieve a truly person-centered planning approach with a program that is based at least 50% or more in their local communities, agencies will need to have a far more staff intensive program.

More participants are expected to transition to CBDS in the near future based on the goals set forth in the Massachusetts Employment Blueprint. In addition, individuals turning 22 years old who qualify for DDS services will enter into services and there are approximately 600 people that remain in sheltered workshops slated to transition because all sheltered workshops are scheduled to close by June 30, 2016. Therefore, we face a prospective fiscal issue given that significantly more will enter the program needing higher staffing supports.

Therefore, given the projected changes that are a result of the CMS rule and Employment Blueprint for Success, there is undoubtedly a significant need for an increase in CBDS rates to obtain additional resources necessary related to the successful operation of quality services. As stated earlier, these plans require closure of sheltered workshops, more individualized services and transportation options, such as small to medium sized vans. Plans also require the ability to support all transportation needs for individuals in rural settings throughout the Commonwealth.

Concerns about original CBDS rates set in 2011

Several of our members were involved in an ADDP workgroup which analyzed CBDS rates when they were initially set in 2011. At the time of ADDP testimony, they identified a number of concerns which have never been addressed in the current base rates to which the CAF is being applied.

We strongly request that EOHHS and CHIA consider the issues outlined below when a full rate review is completed.

As expressed by ADDP in 2011, we were disappointed at that time that the amount of new funding to be added to this service code initially meant that 48 providers would lose approximately $2.8 million of support for programs, if the methodology proposed and DHCFP projections were accurate. This was clearly stated as an attempt to maintain level costs within the service code and to "rationalize rates" in a code where there had been huge variances negotiated across providers. The rate increases were designed to be phased in over three years

to mitigate financial losses for providers experiencing rate cuts. We are particularly concerned about building upon the 2011 methodology for new rates, given a number of significant concerns:

Direct care ratios

There were initial concerns regarding the rationale for establishing direct care staff ratios, which are still being questioned in today's methodology and will require significant adjustments for providers to comply with the new CMS HCBS community inclusion regulations.

Salary levels

Related to these staff ratio issues, the compensation levels for direct care staff in the 2011 model were and still are of concern. The data set provided by DHCFP to ADDP at that time indicated that the salary levels for direct care were taken at the 65th percentile, which would have appeared to adjust these salaries up from 50th percentile levels in contracts. However, while we appreciated DHCFP adjusting the percentile upwards in this CBDS model, it was also clear that there were not any adjustment for cost factor needed for "benefit time", which includes coverage for sick and vacation time. Typically, providers budget for an additional 14% of an FTE for coverage for every FTE of staffing. In Chapter 257 rates set for subsequent codes, costs for more adequate benefit time, plus training time, have been included (such as 40% for Adult Long-Term Residential rates).

Fringe benefits

Fringe benefit costs in the model were also significantly lower than budgeted fringe rates of many providers, which for some of the programs are higher because of longer tenured staff. As history with salaries suggests, providers have had to hold down fringe costs by passing expenses on to staff. Compared to state employees, we continue to believe that the employees of the community provider system have historically experienced an unfair suppression of their fringe benefits, such as percentage of health insurance premiums paid by employer and pension contributions. We would encourage the new rates to recognize this suppression and use a higher percentile for this category.

Clinical behavior management staff

A related issue concerned funding for clinical behavioral staff. Almost all providers are adopting the Positive Behavior Support model proposed by the Department of Developmental Services, which relies on board certified behavior analysts, who are responsible for developing and managing and then training staff to implement behavioral interactions and treatment plans for individuals in these programs. They have been budgeted in contract data and reported in UFRs in different categories, including for this code in the PSIII category. In the FY 2011 CBDS proposal, regardless of how the methodology was developed, funding for these positions was essentially eliminated, as they averaged out of the DSPIII line, and were not included in any specialist lines. As reported above, given the high percentage of individuals in many programs with active behavior plans and the need to properly support individuals with serious behavioral challenges, these programs must have competent clinical staff to develop, train staff and supervise these programs. And over the past few years, competition to hire BCBAs from schools and other non-

EOHHS providers has driven these salaries much higher. The behavioral interventions developed and managed by these staff are critical to our ability to accept individuals with severe behavior challenges and help them learn appropriate adaptive behavior to function and learn new skills in the CBDS setting and the community. We strongly encourage the new rates to allow for funding for these positions.

Occupancy and facility costs

Regarding occupancy costs, we are well aware of the high levels of variability of these costs across providers, and the lack of apparent correlations with geography and year of purchase. This has clearly been a major problem for providers in some settings, as occupancy cost per FTE (or square foot) are about twice the average cost in the 2011 data set, producing an underestimation of costs for those components. We understand from conversations with our colleagues at Bay Cove Human Services and Vinfen, who must also contend with Boston real estate prices, that they have similar problems in their occupancy cost bases. We therefore encourage EOHHS and CHIA to consider a two-tiered rate system, such as the system used for Adult Long-Term Residential rates, in which one tier is developed for facility costs, based on actual costs, with standards and cost caps set by DDS and CHIA, and a second tier based on program costs, driven by intensity of need, staffing ratios, and other program variables already being considered in the cost components.

Administrative costs

Finally, we note that the model proposed a 10.77% reimbursement for Administrative overhead, but strongly support the consistent ADDP proposal that Administrative costs be set at 12.5 %. Adequate administrative funds are needed in order to support providers for administrative costs which increase each year, to take on new State mandates.

Intensity levels for CBDS model & CMS rule requirement costs:

Upon review of your proposed regulations, ADDP has several other concerns that we are hopeful you will be able to remedy once they are brought to your attention. ADDP is concerned that the structure of the seven intensity levels of the CBDS model, utilized by CHIA for this rate analysis is inadequate for determining the rates because it is not aligned with the Department of Developmental Services and the new CMS rule service requirement of full community engagement and person centered planning. The rates as published, even with a CAF of 2.05%, are too low to meet the projected costs that are needed to meet the requirements of the new CMS rule. Agencies will need a significant increase in CBDS rates to obtain additional needed staff, transportation, costs related to recreational activities and other fees, and supplies to allow an individual with the best community integrated experience while obtaining CBDS services.

We are hopeful that you will consider revising the intensity levels by reverting back to the previous system of having intensity levels based on staff ratios rather than removing staff ratios from the description of a person's intensity of need. The previous regulations addressed staff ratios, but this proposed draft removes staff ratios from the equation in assessing rates. Adding staff ratios to the regulation may be beneficial in preventing unintended financial burdens on

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human service providers considering all of the major systemic changes that are now occurring. Furthermore, most of the other rates published by EOHHS reflect the needs and challenges of the individuals served by identifying the amount of staff time, the ratio of the number of staff and the type of staff necessary to serve them.

ADDP strongly supports the CMS rule that requires more person-centered choice and community integration, and requests that the proposed regulations provide the resources needed to best achieve these goals. As stated earlier, in order to best implement the CMS regulations, ADDP service providers project that they will need a far greater amount of staff that is much more than the current staff ratio to support people. Based on the utilization of the current rate structure models, providers are going to need additional funding for smaller staff ratios, more vehicles, more staff, and more consultants and training for staff to ensure that full community integration in accordance with CMS is achieved at the highest level possible. The current rates were adjusted based on fiscal year 2014 data and fiscal year 2015 projections, which is now outdated due to the rapid increase in program participants and the closings of sheltered workshops. There is a significant need and desire to hire more staff to keep up with the changing staff to client ratios, as well as the desire to offer staffers a living wage to help with recruitment and retention. Therefore, ADDP respectfully requests that you take these variables into consideration when finalizing these regulations and including staff ratios for Community-Based Day Support Services under 101 CMR 415.

As stated earlier, if these changes cannot be reflected in this CAF factor, then we urge EOHHS to schedule a full rate review as soon as possible and not to wait the full two years for a full review. Delaying a full review and having process based on outdated information will jeopardize EOHHS ability to meet the new CMS guidelines and the goals of the Massachusetts Employment Blueprint in achieving the closure of segregated facilities.

Thank you for taking the time to hear our concerns today and understanding that what we propose and request is a reflection of wanting to adhere to best practices and apply the best approach for serving individuals with developmental disabilities and brain injuries.

Thank you very much for your time and consideration.

Best regards,

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