ADDP Association of Developmental Disabilities Providers

Community for Living. Community for Life.

December 15, 2015

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

Re: 101 CMR 423.00: Rates for Certain In-Home Basic Living Supports

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 Certain In-Home Basic Living Supports, 101 CMR 423.00. As many of you already know, ADDP represents 130 human service providers who provide services for individuals with developmental disabilities and brain injuries. ADDP is very appreciative of the work put into the rate development, which will support a service containing a broad range of components that assist individuals to live as independently in the community as possible, and foster the type of self-directed, independent living scenario that is congruent with the CMS HCBS Final Rule for community integration.

Rate Calculation & Methodology:

ADDP providers have expressed that the financial basis for the rates contained in the regulations needs to use a broader approach than mere averages from FY14 UFR data, in order to accurately project the costs of properly providing these supports in accordance with the desired goals and objectives. The intent behind the Chapter 257 rate requirements was to ensure that adequate rates were set for the purchase of human services, based on projected service needs and projected costs of services, and not continue the roll forward exercise every year using only available appropriation and historical budgets to drive rate and unit pricing. Unfortunately, the rates specified in the eleven levels (A-K) in 101 CMR 423.03: Rate Provisions (4) Approved Rates, were not based on the costs to meet the service needs of individuals. While it is relevant to examine the cost reports in order to know how the 2014 funds got spent, it is critically necessary to consider those amounts in the correct context. The context is that those budget amounts were developed in FY 13, using what was described by the state as a "roll-over" from the prior year, which was itself merely a roll over from the previous year, and so forth. Therefore, the spending that was reported on the FY 14 UFR was artificially constrained, and cannot be regarded as a reliable basis for projecting a rate that reflects the cost if the desired service was provided in an ordinary competitive employment market. In addition to benchmarking for actual costs of professional services, specific inflationary adjusters to the 2014 data set are required in order to project costs for use in 2018, when these rates will still be in effect. One necessary adjustment is to include a factor for the recent rise in human service salaries and benefits, experienced during FY 15 and FY 16 because of other service rates having finally gone through the rate development process. Another is to include the cost effect of the very recently passed legislation that requires earned sick time for part-time staff. There are also anticipated cost increases to be factored, such as those associated with the DOL change in threshold for

overtime exemption, the costs for national background checks, and rise in the associated costs of health care and health insurance. In general, the area of economic forecasting of the costs for all the components of the service will need further tuning.

Utilization

The budget models recognize that not all hours are spent in direct contact with the individual being served. Therefore, the total cost was structured to be reimbursed based on only the direct contact time. This is achieved by dividing by the estimated maximum available direct care time, after subtracting out standard amounts for meetings, travel, training, time off and the like. We find there to be two compounded issues in this aspect of the models. The first is that the models presume that staff receive an average of two weeks of time off. Based on a quick sampling of our members, that seems unsupportable, in that many have staff with longevity for three weeks off, such that for the average to be two weeks off would require most agencies to start staff with only one week off. We could not find any that low, and could not confirm that representative data from the field was used to arrive at the numbers in the models.

The second issue is that the rate presumes that all of the direct contact hours that a staff person is available for will always be used at maximum capacity. For example, the model estimates that if 30 of the 40 hours are available for direct contact, then all 30 will always be used and thus billable. There is no allowance in the reimbursement model for one of these hours to go unfilled. If staff arrives only to find that an individual is sick, or refuses service that day, or is away with family, etc. then there is no direct time to be billed, and the cost of staff time, travel, availability, etc. becomes unreimbursed.

The Commonwealth currently recognizes this issue and incorporates a mechanism to handle it by using an 85% utilization factor, where 15% of the direct contact capacity is factored out, and thus the rate per billable unit becomes increased. To protect itself from being overbilled, should the service operate at a full schedule every week for 52 weeks, the contract has a maximum value such that the final units are not able to be billed (unless they exceed the allowable usage buffer of the 15%). The Commonwealth is not overcharged, because the provider does not bill when providing units that were factored out but whose costs were included in the rate. Correspondingly, the provider is not expected to find outside funds *to help support the regular operating costs of a Commonwealth program*, because the billable rate includes an allowance for a certain number of hours that go unfilled. We note that the models include an adjustment which reflects that high need individuals may require a greater number of collateral service time outside of direct contact time, but yet there is no utilization adjustment for possibility that any of the estimated direct contact time may not happen. Capable high need individuals often require flexibility, and schedules may not be the same week to week. We respectfully request that the rate models be adjusted so as to allow the Commonwealth to continue its current practice of using an 85% utilization factor in this service.

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Rate Level Service Definitions:

Most rate regulations provide a framework for the purchaser to utilize when applying rates levels to service levels. This regulation is silent as to how each rate level is defined and how the assignment to a level will be assessed and applied. The silence in this regulation *may* result in the purchasing agency using inconsistent methodology, subjective measures, or no standardized process when determining the acuity or needs of the individuals served under this rate. This ambiguity could easily result in inappropriate or inadequate rates of reimbursement since the purchasing agency could choose to define the service needs of the individuals to be no greater than level A, given the absence of the definition of each level within the regulation. This is particularly a concern when we look at page 13 of the RFR, Section III, ¶ 2, which states, "DDS ***primarily*** purchase[s] In Home Supports ***at the lower levels***, but *may choose* to purchase services at the *higher levels* to address the needs of specialized populations." The staff in a DDS area office could easily perceive this language to mean that they are supposed to refrain from using the higher levels, and primarily utilize the lower levels.

Upon review of the service level definitions found in the RFR that correspond to regulation 101 CMR 423.03, ADDP is very concerned that levels G through K require a minimum staffing requirement of a Bachelor's or Master's degree in order to qualify for these levels. DDS has never defined these services based on the educational level of the staff, and many agencies utilize Bachelor's level, Associate's level, and very well trained and long-experienced staff who have only completed High School, to serve some individuals whose profile matches the service needs defined by the RFR to be in the G through K levels. Therefore, many competent, well-trained direct care staff who have developed relationships with these individuals will no longer be allowed to serve them if they are in need of the services found in the higher levels. In the alternative, an area office would have to assign the individual to a lower service level in order to allow the staff to continue to play a role. Given that the description is that each higher level contains the services of the lower levels, it would seem to be an unintended consequence that if an individual began to require more intensive services, that the former staff who were allowed to provide those other services would no longer be allowed, because 100% of the staff serving that person now require a bachelor's degree, without exception for experience. It is not clear how the regulation should speak to this issue, but it would appear that the lack of definition and guidance within the regulation has allowed this development, and ask for your thoughts to improve the application of the regulation.

Thank you very much for your time and consideration.

Best Regards,

Tara Hopper Zeltner

Tara Hopper Zeltner, MSW, LL.M.
Attorney & Director of Governmental Affairs