

DDS Legislative Rate Study Committee
Interim Report - October 2010

I. Introduction

Section 57 of Public Act 09-3 (SSS) and Section 4-1a of the Connecticut General Statutes was signed into law effective October 1, 2009. This Act establishes an Advisory Committee for Services under Programs Administered by the Department of Developmental Services. The committee is charged with studying the impact of the shift from master contract to attendance-based, fee for service reimbursement for DDS funded programs.

The advisory committee members are appointed by the legislation and represent the Governor’s office, legislative leadership, various state agencies; organized labor; and the community provider community. Senator Jonathan Harris, co-chair of the Public Health Committee, was appointed to chair the committee. Pat Bourne was appointed to represent the provider community. DDS is the administrative staff to the committee.

The full advisory committee convened in February, 2010. The statute requires the committee to submit a report to the legislature by January 1, 2011.

The following sub-committees were established to address the various issues outlined in the bill:

- Analysis of Medicaid Waiver Regulations: Mary McKay(DDS) and Mickey Herbst (CTArc)
- Level of Need and Impact on Rates: Terry Macy (CT Non Profits) and Joe Drexler (DDS)
- Information Technology: Janice Chamberlain (CT NonProfits) and Krista Pender (DDS)
- Impact of Attendance: Pat Bourne (CCPA) and Peter Mason (DDS)

The legislation does not specifically address the scope of DDS funded services. DDS initiated attendance based reimbursement for all DDS funded day programs in response to budget rescissions. The committees have been focusing on the impact of these changes for day programs only. Supported Employment Services Independent (SEI) was immediately and obviously adversely impacted by the attendance-based, fee for service system. Commissioner O’Meara agreed to cap SEI losses at 2% pending the recommendations of a workgroup addressing more appropriate rates and fees to better suit the complexities of the SEI model. An additional work group was convened to address the impact of the pending transition on residential services. Detailed reports from those committees will be included in the final committee report.

II. What is the Home and Community Based Waiver?

The funding structure for the Connecticut Department of Developmental Services (DDS) is driven by the federal Medicaid Home and Community Based Services Waiver (HCBS). The HCBS Waiver is an optional Medicaid program that allows states to request a waiver from federal Medicaid regulations to provide community-based services and supports to individuals with intellectual disabilities as an alternative to Medicaid State Plan services such as nursing homes and Intermediate Care Facilities (ICF).

The federal Waiver program, first authorized by Congress in 1981, provides Federal Financial Participation (FFP) by matching state funds expended for waiver services. DDS has had a waiver since 1987, with an FFP rate of 50%, the highest rate available to CT based on federal formulas. According to the June 2009 Management Information Report, revenue of \$392.37 million for DDS services in CT was projected to be generated through the waiver. The breakdown follows:

FY2009 Medicaid Waiver Revenue	
Service	FY 2009 Actual Revenue
(Millions of Dollars)	
Home and Community Based Services Waiver	\$ 270.03
Public ICF/MR	\$ 107.07
Targeted Case Management	\$ 10.79
Birth to Three	\$ 4.48
Total	\$ 392.37

The CT HCBS Waiver program provides an array of community based services and supports as an alternative to an ICF placement. The Waiver allows the State to claim reimbursement for the costs of those services just like a State can claim reimbursement for ICF services. It requires that the cost of those services is, on average, a cost effective alternative to ICF services. Unlike the ICF program which is a facility based model, the HCBS waiver focuses on the needs and support requirements of individuals with intellectual disabilities. The HCBS was part of a DDS shift to an individualized service delivery system that linked eligibility for services to enrollment in the waiver and individual choice of service type and provider.

The cornerstone of the Home and Community Based Waiver is to allow consumers to easily choose and move among providers. Previously, the DDS funding structure in Connecticut consisted solely of master contracts with approximately 136 service providers, which essentially purchased “capacity” or slots. The amount of funding received by service providers for similar services varied since providers were reimbursed in an inequitable manner due to a multiplicity of reasons. This inequity limited the level of choice and portability of DDS participants and caused a wide disparity in the funds allocated to the individual.

History of Rates and Transition Plan

A quick history of contracts will illustrate how unequal funding for the same service began and continues through today. Over the years, the payment for services provided to DDS participants has evolved through several models: 1) from the reimbursement of provider costs; 2) to the funding of a specific program model; and 3) to an allocation of money based on the support needs of the individual. During that time, the number of individuals and the available supports expanded dramatically. Many variables, including the changing DDS management styles and philosophies of the different regional administrative staff, have contributed to the influence of inequitable rates for individual providers. However, there were only a limited number of systemic events that had the greatest effect on rates for the majority of providers.

Day Services

In the early 1980’s, most day supports provided to individuals with intellectual disabilities were in sheltered workshops. Providers were reimbursed by the former Department of Income Maintenance (DIM), now known as the Department of Social Services (DSS), based on the cost of their service. An annual cost report was submitted itemizing all costs expensed by the agency. A day rate for the agency was derived from the cost report and was issued for the following fiscal year. Providers were reimbursed for each day each participant attended the program. The more a provider spent, the higher their day rate would be for the following year. This created a variety of rates in which those agencies that had a positive cash flow would be able to increase their spending to maximize the rate they would receive the following year. In contrast, providers that had limited financial means with barely enough money to meet payroll controlled their spending for only essential items resulting in a continuance of a low reimbursement rate.

In the mid 80’s, DDS moved to a more conventional contractual system to coincide with the advent of community employment programs. Service rates were “frozen” at the rates established through the cost report system resulting in a system where individual allotments for participants with similar needs varied significantly. Since it was a new funding system and rates generally matched agency’s expenses, there was no attempt to equalize the funding. This created the first imbalance in the funding levels. As time went on, the cost of living increases to the day contracts were applied “across the board” and widened the gap. In the late 1980’s and into the 1990’s, a number of agencies with an organized labor contract were provided with additional funding to settle labor contracts. This was the main cause of the gap in both wages and benefits and funding levels between unionized and non-unionized agencies.

As new agencies entered the system, rates were raised to reflect the cost of business at that time. This created even more equity funding problems for the system. As a result, a new provider received a funding level based on current costs while an established provider was still paid a funding rate similar to the one established back in the mid 1980’s increased only by across the board allowances given to the providers over that time. In 2005, DDS moved to a “fee for service model”. Fee for service rates for new individual participants in day programs were applicable for all providers.

Over the years, the Legislators attempted to address the issue of direct care wages. These included cost of living increases, a Low Wage Pool and the establishment of a Blue Ribbon Commission that documented the disparity among private providers.

Despite these efforts, wages continued to increase disproportionately based on funding rates during the years when providers received a legislative appropriated increases.

Residential Services

Similar to day services, all residential group homes were funded by DSS and providers were reimbursed a day rate derived from an annual cost report. The reimbursement rate was based on provider's actual costs from the previous year. In the mid 80's, the costs were separated into the service supports required for the individuals in the home and the costs attributed to room and board. DIM/DSS issued a day rate for the room and board costs and that arrangement continues through today. DDS contracts with providers for the service costs.

Subsequently, DDS developed a system of funding individuals with like needs as measured by a rating system. Known as the RET (Regional Eligibility Team), all new individuals entering the residential system at that time were assigned a funding level based on a scale of 1-5. Providers were reimbursed based on the same level of funding. This system was disregarded after a few years. Funding was assigned based on legislative appropriation and negotiated contracts. In addition, providers would negotiate with DDS for any nursing or specialized supports required to meet the needs of the individual. The inequitable funding level for residential services followed the same track as the day supports in terms of the unionized agencies and the newer providers.

III. Where Are We Today?

Current Funding of Private Sector Programs

Currently, there are different funding levels for different homes and day programs and different amounts for different people with similar needs. In both day and residential services, funding was based on an historical combination of cost, appropriation and negotiation, but not necessarily on consumer need.

Due to the multiplicity of rates and other issues that had surfaced in the early 2000's, DDS researched options to revise the funding structure and opted to develop a unit rate system with the intent to enable consumers to receive supports from the provider of their choice, provide fairer and more equitable funding system based on the level of need of the consumer, and provide an incentive to maximize the resources of the Department. DDS made the decision to start with day and individualized home support services due to the complexity of congregate living situations.

A new day services and individualized home support rate structure was developed in January 2005, with implementation in April 2005. The rates were developed based upon the prior years cost information from the provider community (2003 Annual Report for Residential and Day Services) and wage information from the Department of Labor. The new Fee for Service rate system was limited to first time individuals, such as high school graduates, entering the DDS system and to those existing participants requesting additional supports. All other participants in existing services would remain under the contract service model. This was done as a way to temporarily hold those providers that were above the proposed rates harmless while a transition plan to convert the entire system was established to minimize their financial hardship as the agency continued to serve participants already in their day and residential programs. This has created a dual system of funding – existing services covered under a master contract and individual budgets (IB) for new consumers and for those requesting or requiring changes in services.

A Waiver Workgroup, a collaborative effort between DDS and the private sector, was formed in April 2005 to address fee for service rates. The Waiver Work group researched the methodologies used by many states before embarking on any changes to the rate structure. The group established a goal to transition providers to uniform rates over time and implemented a voluntary pilot to test the Fee for Service rates. The pilot was intentionally limited to those providers calculated to receive reimbursement from the Fee for Service rates somewhere between 5% above and 5% below their current contractual amounts. The supposition was that if these providers could not remain financially viable under the proposed rate structure, then DDS would need a more sound approach. The sample of providers determined to be eligible for the pilot was small, but instrumental in determining the need for a multi-rate system based on a participant's level of need.

Among the other changes proposed by the Waiver Work group and implemented by DDS were:

- The establishment of a utilization factor for attendance to the original drafted rates to include an 86% attendance factor for providers who pay DDS consumers for vacation time and 90% for all other providers.
- Staffing Modifier
- Transportation payment changed from one way to a round trip.
- Handicapped accessible transportation rate developed
- Summer camp rate added as a service based on LON
- Mechanism to fund an additional staff for transportation needs
- Web based billing
- Committee formed to address fee for service rates in individual home settings

The current funding structure for Connecticut has been driven by the Department's mission of participant choice and self-determination and the federal waiver mandates from the Centers for Medicare and Medicaid Services. This system has evolved to where new participants and any participant currently receiving services that requires additional supports are allocated funding based on the participant's Level of Need. The Department recently initiated and is continuing to refine the process of attaching funding based on the support needs determined by the LON. Once funds are allocated, the participant can utilize those funds in three ways: 1) self-direction whereby funds are used to self-manage services; 2) use the funding allocation to obtain services under a rate based system from a qualified service provider; 3) use the funds to obtain services from a qualified service provider through a Purchase of Service contract. According to the June 2009 Management Information Report (MIR), 959 participants self direct their services. As of 9/30/2009, there are a total of 3,807 participants served by the department with an individual budget that utilizes the Fee for Service rates. For that portion that has moved to uniform rates, private providers bill a Fiscal Intermediary for each unit of service provided. This represents an estimated 24.7% of the total 15,390 participants served by DDS as reported on the June 2009 MIR.

As a result, we now have a dual system with 25% of consumers on individual budgets based on fee for service and the majority remaining on master contract.

Transition Plan and Issues

Every state grapples with the need to meet the federal mandated waiver requirements to transition to uniform rates and the conversion from a contracted based system to a Fee for Service system is a major undertaking. In Connecticut, the change for DDS providers would require modifications to their business operations in two main areas, adjusting costs based on unit rates and adjusting funding levels based on utilization. Taken separately, the transition would be difficult for most providers. When the two were added together, the conversion problems are compounded and increase the anxiety and fears of the provider community.

Attempts to obtain information from other states for the purposes of this study had limited results. However, it appears few states have as wide a range of rates as the current system in Connecticut. Some states have created transition plans with as many as 10 years to get to the standard rates. Others have run extensive pilots of their rate systems to determine the potential problems and challenges of their plans prior to implementation. The difficulty is not in the "why" of change, but in the "how".

DDS developed plans to transition all providers from their current rates to standard rates through a 5 year transition plan. The plan would reduce rates for those providers above the established rate and use those dollars to increase the rates for those providers funded below the established rate. The community provider system expressed concerns that in a system already significantly underfunded, reducing rates for any provider in the system would have serious implications for the stability of the provider network. The plan was to go into effect on 7/1/09.

Section 57 of Public Act 09-3 (SSS) and Section 4-1a of the Connecticut General Statutes was signed into law effective October 1, 2009. This Act established an Advisory Committee for Services under Programs Administered by the Department of Developmental Services. The committee is charged with studying the impact of the shift from master contract to attendance-based, fee for service reimbursement for DDS funded programs. The passage of the legislation put all transition plans on hold.

However, as part of the state's ongoing efforts to reduce the budget, DDS received a series of budget rescissions cutting over \$5.9 million from the DDS budget in FY2010 and an additional \$1.25 million in FY2011. In response, DDS initiated utilization (attendance) based payments for Purchase of Service contracts for all funded day programs effective 2/1/10. Day program

providers receive a day rate, based on a 90% attendance factor, for each individual consumer based on the current contractual amount.

Condensed Rate Timeline:

- 2004 Draft Rates for the Individual and Family Support (IFS) Waiver were disseminated.
- 2005 Waiver Work Group to review the methodology and implications of the IFS Rate structure.
Fee for Service rates were implemented for new participants.
- 2006 Pilot Program began with 4 residential providers and one day provider.
- 2007 A new draft rate structure was proposed for group day services.
Rate analysis of the new rate structure sent to providers.
- 2008 A transportation rate was implemented for individuals who required a handicapped accessible vehicle.
A committee was formed to discuss In-Home supports and indirect costs.
- 2009 A new rate structure for group day programs was developed that incorporated level of need supports requirements with the previously established rate.
In-Home supports committee made recommendations to the Waiver Work group for a new rate structure.
A transition plan was developed to convert contracted day services and individualized home supports to the Fee for Service model.
Transition to Fee for Service put on hold. A Legislative Committee on the Fee for Service Program was enacted later in the summer.
- 2010 Utilization based payments implemented for day service programs

IV. Legislative Rate Study Sub-Committee Analysis and Reports

What is the Rationale for Changing the Current Payment System in Connecticut?

The existing payment system between DDS and the private sector agencies that support citizens with intellectual disability throughout Connecticut is incompatible with contemporary federal requirements set forth by the Centers for Medicaid and Medicare (CMS). CMS is the federal agency that administers Medicaid programs across the country, part of which are the Home and Community Based Services Waivers. Through the HCBS waivers, CT citizens with intellectual disabilities receive necessary community-based services paid for by the state, and the state in turn receives Federal Financial Participation (FFP) for up to 50% of the costs. This federal revenue stream is essential to the state of Connecticut.

CMS has articulated its requirements to states in the regulations for the Homes & Community Based Waivers. Waiver regulations requires that states have a uniform rate setting methodology for service models; that states pay only for services actually delivered; and that states afford service recipients freedom of choice between service providers in order for the state to qualify for FFP. Connecticut's existing payment system does not meet any of these three criteria and places the state at risk of federal recoupment of FFP should the state undergo a CMS audit. This comprises a compelling argument to change the current payment system in CT.

Level of Need and Impact on Rates

Since the waiver requires that funding be based on an individual's level of need, DDS developed a validated level of need assessment tool in 2005. There have been no structural changes to its design since then. Throughout the tool's development that began in 2005 and before its widespread use, its design was revised to ensure more accurate determination of need.

Subsequently, the subcommittee reviewed multiple data sets that illustrated LON scores distributed across several disability groups and day program categories. While by no means a scientific inquiry, the results appeared to reflect what one would expect, that the more complex the need the higher the LON scores. Again, these results provide little more than observable correlations. A more rigorous statistical review of variances between groups would need to be conducted to make any statement of authority. It does need to be noted however that even this review found some of sub sets of the disability groupings yielded inconsistent results. These “outliers” included persons with a diagnosis of Prader Willi, pica, autism and some elderly.

Two other considerations appeared to support these original findings. The first was the sampling of a large group of high school graduates. Their scores appeared to be very consistent with expectations. The other variable of note was that as LON scores were being conducted at individual annual reviews early scoring errors were being found and corrected. Again, this is an anecdotal conclusion and not the results of rigorous statistical analysis.

A recurring issue that has been discussed is the overall sensitivity of the LON to address not only the “Outliers” but to the general population it measures as well. This concern begs the observation that “How good the tool is” is a different inquiry than “Is it a valid tool” but probably merits additional and ongoing consideration.

There are only two other assessment tools currently being used throughout the country. The most comprehensive is the AAIDD’s Supports Intensity Scale (SIS). This tool was among the assessments reviewed by DDS and advisory committee before deciding to develop the LON. A recent national study found that the SIS is being utilized in 12 states in their waiver programs and 17 more are considering its use.

Recently, a suggestion was made that because there seems to be concerns for the sensitivity of the LON that perhaps there should be a study conducted to compare the results of parallel measures of a study group with both tools. Among the many potential issues with this approach is the obvious fact that they are wholly separate tools. While they each have their own validity measures they in fact measure different variables and in some cases the same measures differently. Unlike the LON, the SIS is a very complex tool that requires anyone using it to complete rigorous training before being certified to use it. Comparison scoring of a study group would not result in a finding of the LON’s validity but merely an examination of the variability of scope of measures of the two tools.

Connecticut is by no means alone in its choice of employing its own tool. Our subcommittee examined this issue in its own review of programs and found that in our relatively small sample, both Nebraska was going to be using their own “Long Term Care Needs Assessment Tool” and Minnesota was using their own COMPASS tool.

Recommendations:

- There must be rigorous attention to who is completing the LON and under what circumstances it is done. There continues to be reports that it is not being done within the interdisciplinary team process and therefore the best informants are not present to give input and assure accurate scoring.
- Continue to examine scoring results across all populations with more specific review of the “Outlier” populations.
- Examine how well LON scores translate to the rate setting process

Impact of Attendance-Based Reimbursement

The committee is attempting to answer the following questions:

1. Is there justification for attendance based reimbursement under CMS regulations?
2. What is a “reasonable” attendance factor? How is that factor determined? Is there evidence to support that factor?
3. What policies, procedures and systems should be in place to encourage best practices and to safeguard clients? What examples and lessons learned are available from other states?
4. What is the adequacy and accuracy of the current attendance reporting system? Is it audit compliant?

The 5 months of available data shows:

- Overall attendance percentages have consistently increased monthly. The overall analysis by program type shows attendance for all agencies fairly consistent at 88-89%. Data for the period 2/1/10 – 6/30/10 shows a 88.15%

attendance factor for all contracted day providers. Most agencies have not yet fully implemented their attendance management systems.

- There are minimal percentage differences between programs and/or service types.
- DDS should look at the “outlier agencies” to determine reasons for extremes in attendance and provide assistance as needed
- There is no apparent need (based on 5 months of data) to provide variable rates for DSO or GSE based on attendance (this does not address level of need or supervision required). This may be subject to review and more data becomes available.

What can we learn from the 5 months of available data?

- Are day program only providers at a disadvantage? While it appears that agencies who provide both day and residential services have a generally higher attendance percentage, a review of the data for day program only providers shows the overall attendance percentage based on 5 months of data is over 90% (Note: Attendance percentage for the 25 agencies that provide only day programs is 88%. Of those 25 agencies, 12 agencies were below the average (at 86%) and 13 agencies were above at 90%.)
- Issues affecting attendance, such as doctor’s appts., attendance at Individual Planning (IP) meetings, etc. – require a change in “culture and attitude.” Meetings and appointments can be at different times or within a time frame to ensure attendance at program for the 2 hrs./46 mins. required to constitute a full day.

Recommendations:

- DDS should continue to find ways to include reasons for participant absence in the data collecting system (this may also be a topic for the IT sub-committee)
- DDS continue to collect data for committee review and analysis to determine trends and impact.

Information Technology

The committee is charged with reviewing billing systems and documentation systems to identify information technology hardware and software and related costs.

The current IT system at DDS to obtain all master contract attendance data is “WebResDay”, a web-based system providers utilize to report consumer attendance. WebResDay is driven by the ECamris consumer records and records master contract attendance only. It does not record attendance for consumers on Individual Budgets paid through fiscal intermediaries (FI).

Some providers have developed and/or purchased their own systems to track and document services provided and to compile the many details required for WebResDay. Many providers do not use any computerized system to track and document services.

The following considerations are recommended for any IT system:

- HIPAA security compliant
- Upload/download capability for DDS/DSS/provider/fiscal intermediary interfacing
- Web-based
- Capability to monitor services provided compared to billing data transmitted
- Capability to capture documentation of services provided so data is electronic
- Ability to view Level of Need (LON) and Individual Budget (IB) data
- Ability to allow view access to various levels (case manager/fiscal intermediary/provider/families/state agencies, etc.)
- Ability to document Individual Plan (IP) goals to allow service documentation to coincide with IP (audit compliant)

The current waiver regulations require providers to document the delivery of services in the type, scope, duration and frequency outlined in the Individual Plan. The committee recommends the documentation system be able to capture electronically the billing data and the full detail on services rendered in order to have that data available upon request.

The future system should document the following processes:

- Assessment of needs/services (LON)
- Individual support needs and desires
- Individual Plan
- Service authorizations
- Service provision
- Documentation of services
- Billing of services

The next step is to research and identify the “related costs” of the IT system presented above. However, in light of the current economy, it is recognized that this would be a major, but necessary, investment for the state. DDS is in the process of preparing an Advanced Planning Document (APD) grant application. This is a request to CMS for funding to develop the data applications of a management information system needed to meet the HCBS waiver assurances. An approved APD assures a state of 90% reimbursement for all IT development costs and 75% reimbursement through FFP for the ongoing system maintenance costs. This would be incredibly helpful to create a viable, state of the art management information system that would assure the availability of comprehensive tracking data while creating efficiencies for both public and private sector staff.

Summary of Preliminary Findings:

- Medicaid Waiver regulations establish attendance-based, fee for service and uniform rates as the expected standard or reimbursement.
- The current Level of Need (LON) screening tool, if used correctly, is a valid tool to measure level of need. (However, there is a question as to whether the LON accurately reflects certain diagnoses i.e. autism, mental health, etc.)
- There are not currently established IT systems to effectively manage the documentation requirements. DDS does not have the capacity to manage the system requirements.
- While there is limited history and data on the impact of the attendance-based systems, the overall attendance percentage has increased each month. With 5 months of available data, overall attendance percentage is 88-89%. There is no significant distinction between day providers only or program service type.
- The committee sent out a national survey to determine Medicaid Waiver practices in other states. The information on the responses to date will be included as available in the final report.