COPA
Coalition Of Provider Associations
Representing More Than 250 Provider Agencies in New York State

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Provider Association Meeting Minutes – October 16, 2017

1. **CCO Transition**. OPWDD is developing a transition plan for the implementation of both care coordination and managed care for release this fall.

2. **02 Waiver Amendments**. There are two issues that remain pending – respite rate revisions to be effective retroactive July 1, 2017 and high needs rates methodology.

3. **Sheltered Workshop Transition**. 71 of 72 transformation proposals have been reviewed covering about 7,000 individuals. 5 workshop providers are proposing closure. 30 workshop providers have proposed for transition to integrated business. The remainder are expected to transition to Day Hab, Pre-Voc, Pathways to Employment, etc. Ceylane Myers-Ruff's positon is still vacant.

4. **ISS Workgroup**. OPWDD will be forming a work group, headed by Mary Ellen Moeser, on ISS payment and processing issues to bring forward provider concerns. Each provider association will be asked to submit an individual to be appointed to the ISS work group.

5. **Article 16 Clinic APG Rates**. Many Article 16 clinics have reported substantial operating deficits. Providers are requesting an increase in APG rates to address increasing costs. Similar concerns were raised for the Article 28 clinics, and the number of mandated services for our folks are being affected; OPWDD has agreed to get DOH to the table on the issue. There will be a webinar on clinic costs and units reporting since there still is some confusion particularly on DOH's AHCF cost report where both Article 28 and 16 costs are reported. Many Article 28 clinics are unable to employ certain specialty services like Neurology and Psychiatry due to the very high hourly rate that the physicians charge. This may also affect certain Article 16 clinics. And finding these services elsewhere is very difficult.

6. **Template Billing Review and Recoupment of Overpayments**. OPWDD has identified providers that have billed for template funding for individuals who were not eligible for template funding. Last June, providers received letters identifying those individuals. OPWDD conducted a review of its list of individuals who were not eligible and identified about 700 individuals for whom template funding was claimed, but were not eligible. Claims will be adjusted based upon the difference between the template rate and the provider's regular rate and recoupments will be stretched out. Providers should receive letters from OPWDD by the end of the month. For any large claim, OPWDD will work with providers on repayment plans.

7. **ESSHI Supportive Housing Award Update**. OPWDD has secured access to this funding source – primarily intended to address homelessness – to support housing for persons with I/DD. However, ESSHI does not permit certified housing. OPWDD's own program only includes

supportive IRAs since the federal tax credit program prohibits 24 hour support. Twelve I/DD agencies statewide received ESSHI awards.

8. **Medical Marijuana Update**. DOH has released emergency regulations to address the needs of individuals living in facilities and other residential programs. DOH has created a new category of "facility care giver" to expand the statutory provision permitting a "care giver" to be approved for participation in the state's medical marijuana program. Even if OPWDD providers could qualify as a "facility care giver," another issue remains regarding the nursing board and its position on dispensing of medical marijuana by nurses. Also, the issue of cost remains because Medicaid cannot be used to purchase medical marijuana. The DOH contact for questions is (866) 811-8957 or MMP@health.ny.gov. at OPWDD, Nicole Quackenbush, (518) 402-0705.

9. **IPSIDD Update**. OPWDD has concluded that the problem with reimbursement for dual eligible requires a statutory amendment. OPWDD is pursuing the matter with DOH and DOB since a "fix" has budget implications.

10. **High Needs Proposal for Day Services**. 02 Amendment includes a proposal for higher reimbursement for Day Hab services for high needs individuals similar to the program for high needs individuals in Residential hours. In Day Hab, the additional financial support is limited to direct support hours and does not provide support for additional clinical hours. There will be three acuity levels with additional direct support hours per unit of Day Hab. OPWDD will be holding a webinar on high needs processes for both Residential and Day Hab services. They hope to have training in place during the first week of November.

11. **CAS Validation Study Update**. Currently 15,400 CAS assessments have been performed with highest level in the downstate region. The CAS Validity Study will be released this week and OPWDD will be holding webinars to review the findings.

12. **OPWDD Rates**. Because of an error in IRA (supervised and supportive) rates in the acuity adjustment and in the capacity calculation, all rates have to be recalculated. Day Hab and Pre Voc rates were loaded. DOH will provide an explanation of the error so that providers can track the issue in their own rates. Issues were raised regarding the methodology itself and particularly the impact of the WEF on providers serving high needs individuals. This problem will not be resolved by the new high needs methodology because this methodology only addresses hours, not salary per hour. Providers that pay wages higher than the regional average because such providers are serving high needs individuals are being negatively impacted by the WEF. DOH anticipates releasing rate adjustments effective January 1, 2017, for occupancy rate, BFair2Direct Care and minimum wage adjustments by end of November. Providers should be reminded that any concern about Day Hab or Pre Voc rates, such as perceived errors in authorized units, should submit their question/objection as early as possible as the 90 day clock began 10/6/17. For agencies with people in certified residences who are past the 14 Retainer Day billing limit, DOH has seen this issue on their own and will be looking at the data. They have to reconcile the number of days and dollars agencies are losing as a result of long term stays in hospitals and nursing homes.