**OPWDD Provider Association Meeting**

**DDAWNY Notes**

**January 22, 2018**

Commissioner Delaney’s Report

Many comments on the transition plans are being revised based on the comments. Policy and final documents will reflect the comments and thoughts.

Designated 6 CCOs. Others who are applied are still being reviewed.

Have been working very closely with CMS to get needed approvals. Conversations have been very productive, much better than in the past. The Government shutdown will create a temporary pause, but are hopeful these will get up and going quickly once resolved.

Notice of Autism Forums- a Bill was signed by the Governor to create a council. The group is now holding listening sessions. Please encourage people and families to attend to give recommendations on how the needs of people with Autism can be met. This is more than OPWDD, this is across all state systems.

Ensure all data for people served is up to date in CHOICES. Letters being sent regarding the transition to CCO’s will go out to addresses in CHOICES.

Executive Budget

Payroll tax changes- a report was issued last week which provides a good understanding of the impact. Joanne Howard will send this out.

Benefits through state healthcare- still in discussion with DOB.

ICF Conversion

When they convert, all the hours will go over to the IRA at the IRA rate, not the ICF rate. Providers expressed concerned because the ICF has the most disabled and the IRA rate is insufficient. Providers are saying, why should I convert?

Have converted 165, 30 more in review which should be completed in the next month.

Fiscal policy in 2014 was a cost neutral policy. In the case where the rate wouldn’t support it, a supplemental payment would make the provider whole. Plan was in 2017, CAS would set the rate. Unfortunately, rates aren’t being set on CAS results at this time and therefore a new plan needed to be drafted.

Instead we’re going to an hour’s neutral policy. Agency wide, not site specific. That data wasn’t available and therefore couldn’t be used. This applies to DSP and Clinical hours. The ICF hours are being added to the IRA rate.

Conversation rates will be billed for those who were in the ICF. Everyone else at the IRA will be billed the same as they are now.

A Fiscal Policy coming out will explain how this works and give an example. It should be out by the end of the week. Not committing to getting rates out ahead of time, but once the example comes out, Agencies can calculate their own.

Providers suggested to give providers the conversion rate and let them see if they can live with it before they convert.

The Conversion rate will stay into effect until a full year of costs are reflected into the CFR, then rebasing will occur.

Employment Update

**SEMP enrollment delays**: There are many reasons why they are occurring. OPWDD would like to have a separate discussion and get specific examples. Based on some of the questions raised, one main areas of concern is the denial or delay in Individuals currently in Day Hab enrolling in SEMP. There are many pre-employment services (Pre-voc, Pathways) which are intended to provide necessary skills needed to gain successful employment. SEMP is the step after prevocational services where a career and vocation plan are created and the person gains community experiences.

To be enrolled in SEMP first, seems counterproductive. Looking for a vocational plan before enrolling in SEMP. ETP Applications are half completed in CHOCIES, service amendments aren’t being submitted in a timely fashion.

**Pre-Voc ADM**: comments will be accepted. Site based date of service contemporaneous- most of the time it’s in a group setting and the concern is if you wait until the next day, you may not recall what services were provided to each person. Have heard the concerns related to this, but In terms of documentation, all that’s required is a checklist, not individual notes. Therefore it seems the checklist can be done that day.

This does not impact non-site based pre-voc.

Providers expressed concern with the various things that could come up on a shift causing a delay in completing notes. Providers brought up the concern that OMIG will take this isolated definition of contemporaneous and apply it to other programs. Instead of using that word, give a very specific timeframe, hard deadline.

Comments will be accepted, a new ADM may be considered. Legal staff spoke up and said a revision of the ADM would require a new comment period, but changes could apply retroactive. The Commissioner said she heard the concerns and will consider making the modifications. She asked for feedback related to what timeframe would be acceptable to providers.

Send comments to Willow who will forward to the regulatory affairs unit.

Workshop Transformation

All 68 providers who submitted plans have received a response.

What was considered in making the determination- Level of detail on integrated business, timeline to meet the HCBS requirements. Demonstrated a good PCP process and each person impacted was offered a full array of OPWDD services. Even though decisions were made, there is still an opportunity for dialogue and approvals for new enrollment. Letters would be based on the plans submitted, but discussions should be ongoing.

19- Approved for new enrollments

25- Continued site based enrollments (mean people can stay, but no new enrollments)

24- Not continue site based enrollments

A provider questioned if the site based pre-voc setting could be used by community pre-voc. OPWDD indicated 2 hour limit is acceptable for the purpose of gathering and some training.

Intensive Respite Approval

Regional Offices have created a mailbox to accept applications.

Purpose of this service is to give staff training the tools and resources to safely provide the services. Staff should have a plan on how to deal with and prevent specific behaviors.

Revised the process to eliminate the requirement that the plan has to be submitted upfront, but the other documents outlining why the service is needed and request approval before the plan is created. This way if the service isn’t approved, the provider didn’t waste time creating a plan.

Providers expressed the following concerns:

Some regions are unaware of the mailbox address.

A formal plan from a licensed professional isn’t needed for every person, but that’s the only way to get the services approved. Costs providers a significant amount of money.

Many providers are having trouble getting the Policy approved, holding up all applications. It would be helpful if OPWDD could provide a sample or key points required to be in a policy. Abiba indicated they will provide this or having regional offices hold a training, but in fact there is no requirement for a “policy”. She will clarify with the regional offices. It may just be a difference in language.

If one document needs revision, the entire file has to be re-uploaded when a revision is made. This is a burden on providers. Abiba indicated this should not be the case and she will follow up with the regional offices.

CAS Update

Over 21,000 CAS Assessments have been done.

Quality review processes will be completed with IAC to ensure accuracy and satisfaction.

Will have a workgroup to review concerns with the CAS.

Creating a customer feedback loop so that there is an ongoing opportunity to give feedback.

HCBS Settings Update

Compliance date 2022- OPWDD is in the process of determining what regulations need to be created in order to be “systemically in compliance” with the rules.

25 Guidance documents were repealed by Jeff Sessions. Integration mandate was one of them. The law doesn’t change, just the guidance was removed.

Statewide transition plan- not yet approved

Heightened scrutiny- going over feedback with DOH later this month.

Merger and Consolidation ADM Update

The draft has been updated based on feedback and it’s close to being released. CMS approved the policy related to whether a provider transfers service/program through merger or auspice change. If it’s coupled with emergency, the provider gets the higher rate. CMS said absent that emergency, the rate of the assuming provider prevails (even if the rate is lower). OPWDD is working on better defining “emergency” situation to allow providers to be plan full in these take overs while still meeting the definition to get the higher level of funding. PA reps will be asked to review and give feedback before its finalized.

CCO Update

6 applicants received the Initial Designations Letters on 1/12/18

Health Home State Plan Amendment (SPA) formal submission being finalized. 1115 Waiver Transition Plan submission to CMS planned for Feb, following stakeholder feedback.

Coverage in all regions by at least 2 CCOs.

On schedule for a July 1 start date.

Extensive comments received on the Transition Plan. Goal is to have revision out in Feb. Changes will not be major, just clarifications.

Discussed the way to engage staff other than MSCs in education related to the Life Plan and how that differs from the ISP. The Life Plan replaces the ISP. OPWDD said the CCOs will be responsible for this communication, but because they operate their own services as well, they will also be communicating.

The Life Plan will go into effect at the person’s next plan review. There is some discussion about expanding this timeframe during this transition. For example, if the person’s ISP is due for review in August, it’s possible they will have longer than August to complete. Some discussion about Level of Care renewals being delayed.

In advance of July 1, the CCOs will receive the Tier the person will be assigned. The Tiers will be based on the DDP2s.

Rate Transformation Update

8 work groups identified

* Higher needs
* Dc hiring crisis
* Clinic APG Base Rates
* CAS and Development of at risk rates and acuity
* VBP
* At Risk Providers
* Cost report accuracy/OMIG Audit Protocol
* ICF transition

Need upstate provider representation on these groups.

Resubmitting CFRs for consideration in 7/1/18 rates

Providers notify DOH they wish to resubmit the CFR and DOH will let the provider know if they plan to accept it. A detailed list of the exact changes will need to be submitted with the CFR. CPAs are required to recertify the new CFR. Any not recertified will not be accepted. Requests need to be done formally. Forms will be placed in OPA in What’s New section.

Rate Update

Rate impact by program will be given to PA reps and will show impact of all Agencies, by the end of the week. Looked at each program individually. Budget Neutrality was calculated by individual program.

Recoupment schedule for negative retro payments:

16 million in liabilities created by 76 Agencies. Can’t suspend liabilities because the recoupments are being given to others. 15% out of every Medicaid check until it’s repaid. Donna could not answer if it’s 15% of all Medicaid or just that program. She will find out.

21-10 rate run will be the first run where the rate adjustments take effect.

Jan 31st- those providers off the lag

Feb 14th- those providers still on the lag

There will be a netting out between programs. For example, if you owe in DH, but gain in Residential, the DH repayment will be taken from the extra Residential. In this scenario, if you have direct deposit, you will not get payment that way. You will get a paper check. The check should arrive within a few days of the normal direct deposit.

For providers who have an extreme hardship paying the funds back at the 15% rate, there is an option to negotiate an alternate pay back, but funds paid back outside this methodology will be paid back with interest, prime +2.

2/1/18 1/1/18 rates processed for release – minimum wage and 3.25%

2/9/18 Deadline for CFR Requests from resubmission

3/2/18 Deadline for revised CFR submission along with misc documents

6/1/18 Revisit budget neutrality calculations and use of corridors

7/1/18 Rates issued based on revised 2014/2015 and 2015 CFR information