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July 1, 2020

Howard Zucker, M.D., J.D.

Commissioner of Health

Corning Tower

Empire State Plaza

Albany, NY 12237

Theodore Kastner, M.D., M.S.

Commissioner of OPWDD

44 Holland Avenue, 4th Floor

Albany, New York 12229

Via E-Mail ONLY peoplefirstwaiver@opwdd.ny.gov

Dear Commissioner Zucker and Commissioner Kastner:

On behalf of DDAWNY, the Developmental Disabilities Alliance of Western New

York, these comments are being submitted in response to amendments being proposed to the current 1915(c) OPWDD Comprehensive Home and Community Based Services (HCBS) Waiver (NY.0238-Amendment 03) for the period beginning October 1, 2020.

DDAWNY is a collaborative group of member voluntary agencies providing

supports and services to people with developmental disabilities. While honoring

individual agency missions, it is the intent of the Alliance to assist agencies to develop

relationships, promote unified strategies and share risks for the mutual aim with and for

the benefit of people with disabilities.

DDAWNY member agencies employ over 22,400 individuals in the seventeen

Western and Finger Lakes counties of New York State providing supports and services

to over 33,000 individuals with developmental disabilities and their families and/or circle

of supports. DDAWNY has also formed a Family Committee to give voice to the people

served in the disability arena, but whose voices are often unheard.

DDAWNY has reviewed and pursuant to 42 CFR 441.301(c)(6)(iii), 42 CFR

441.304(f) and 42 CFR 447.206 is pleased to provide comment on the changes to the State's methods and standards for setting payment rates for several services currently contained in OPWDD's approved Comprehensive 1915(c) Waiver for the period October 1, 2019 – September 30, 2024.

The Waiver amendment proposes changes to the methods and standards for setting payment rates for Supervised Residential Habilitation for voluntary providers and seeks to implement new clinical review tools for the authorization of Community Habilitation services. The amendment also proposes certain technical changes streamlining documentation requirements, clarifying the timeframe for applying the current $15,000 cost limits (subject to medical necessity) for Assistive Technology, Environment and Vehicle Modifications and standardizing rate setting regions for the Community Prevocational service.

DDAWNY has concerns regarding the imposition of new clinical review tools for Community Habilitation Services. While OPWDD indicates it is intended to provide consistent, efficient, and fair decision making in the authorization of Community Habilitation, the draft guidance document outlining what these review tools are and how they will be implemented have not been released. The absence of this draft guidance prevents any ability for the public to make meaningful comment on what OPWDD concludes, without providing the underlying factors, will be “consistent, efficient and fair decision making” in the authorization process. DDAWNY opposes any service authorization review process using the flawed Developmental Disability Profile (DDP)-2 tool to determine acuity as part of the authorization process for Community Habilitation. DDAWNY urges CMS to reject this proposed amendment until such time as the Coordinated Assessment System (CAS) tool is finalized.

The new State assessment structure, the Coordinated Assessment System

(CAS) has still not been finalized and OPWDD continues to rely on the outdated deficit

based DDP-2 Assessment tool to inform rate setting and utilization. DDAWNY continues

to object to the use of DDP-2 scores to measure acuity and for rate setting purposes. The DDP-2 instrument is flawed and should not be used for rate setting or utilization purposes. DDAWNY believes OPWDD and the State need to finalize the CAS acuity scoring and applicable due process appeals processes for any disputed acuity scoring prior to making any further changes in either service authorization or rate setting,

In early January, the roll out of the Coordinated Assessment System, Resource

Balancing Model Project (CAS-RBM) was publicly announced. At the time, OPWDD

indicated the agency would include a review of the CAS-RBM project timeline, purpose,

process, and output of the final model variables and validation, tier descriptions, and

stakeholder themes. Thereafter, the presentation was abruptly cancelled and has not

been rescheduled. This is a critical component of both rate setting and service authorization.

In developing the current rate setting methodology, New York State and CMS agreed that the rate methodology must be “understandable, delineates all elements in the rate methodology, and describes how all components are factored into the methodology. The methodology must assure that the rates produced are economic and efficient and lead to quality outcomes for beneficiaries.”[[1]](#footnote-1)

DDAWNY and other Provider Associations have objected to the use of the Developmental Disability Profile (DDP) tool as an instrument to determine and adjust for acuity since the beginning of the development of the new OPWDD Transformation Methodology in 2013. In a letter to then CMS Director Cynthia Mann in February of 2014, three Provider Associations, Cerebral Palsy Associations of New York State (now CPState), the InterAgency Council of Developmental Disabilities Agencies, Inc. (IAC) and The Alliance of Long Island Agencies, indicated:

“*The central problem with the IRA residential habilitation rate-setting methodology is the utilization of the Developmental Disabilities Profile (DDP) as the instrument to determine and adjust for acuity. This assessment instrument, which has been used for many years by OPWDD, was never designed as a tool to allocate direct care hours among providers serving individuals with developmental disabilities. Moreover, the State has acknowledged the weakness of the DDP as a tool to assess acuity and is developing with the support of CMS a new assessment instrument (the Coordinated Assessment System or CAS) as a replacement for the DDP.*

*“The State has acknowledged that the CAS is needed to ensure accurate identification of the needs of individuals; better align resources with individuals' needs rather than with program models; and secure consistent assessment across settings and in different geographic regions – all factors lacking in the DDP. The State has advised us that it is planning on conducting testing of the CAS instrument this year with a roll out planned for 2015.”*

In a March 12, 2014 response, CMS indicated:

*“It is also CMS’ understanding that the DDP would be utilized as a short term solution for adjusting acuity levels for individuals receiving services and that the Coordinated Assessment System (CAS), a new tool that has been specifically tailored to capture the unique health and support needs of individuals with developmental disabilities in New York State, will replace the DDP shortly.”*

Six years later, New York is still using the DDP to score acuity and to inform rate setting. CMS should not approve any further changes in New York’s 1915c Waiver in relation to service authorization or rate setting until the CAS is actually finalized in New York State.

DDAWNY strongly objects to the changes being proposed to the Supervised Residential Habilitation rates, particularly the elimination of any occupancy factor to address vacant bed days, the 50% reduction in Retainer day and Therapeutic leave day rates and the 96-day limit per rate year per person on the payment of Therapeutic leave days. These proposed rate changes move New York away from a cost-based rate structure toward an arbitrary budget-driven rate structure that meets the preference of the State agency to live within its self-imposed budgetary cost targets. OPWDD has targeted voluntary non-profit residential service providers, without regard for the damage these rate changes will cause these providers, how these changes will impact the availability of certain safe housing options and the quality of care to the beneficiaries seeking certain community based residential options.

OPWDD could have mitigated or even eliminated its resource shortfall by strictly controlling agency overtime or shifting more service delivery from the State-operated programs to services and programs run by voluntary providers. State-operated residential programs are significantly more expensive and less efficient than programs run by the voluntary sector. Other options include a re-estimate of agency spending as a result of the COVID-19 pandemic. Indeed, as a result of the COVID-19 pandemic, OPWDD is saving substantial money. Day habilitation services have been closed for nearly three months. Community, site-based respite is not being authorized, and providers report a substantial reduction in the level of Community Habilitation services being delivered. OPWDD has been quite candid – these rate reductions are required in order for OPWDD to address its 2020-21 state fiscal plan resource allocations not for the purpose of ensuring that the rates produced are “economic and efficient and lead to quality outcomes for beneficiaries” as required by CMS. CMS should reject these rate amendments.

DDAWNY has supported the development of a cost-based rate structure and is committed to working with OPWDD and CMS to develop and support a rate reimbursement methodology that promotes equity, sustainability, alignment of the financial platform, and incentives for the appropriate delivery of supports and services leading to the outcomes desired by people with developmental disabilities and their circle of support based upon their properly assessed needs.

The State in developing the OPWDD Transformation Methodology was guided by the following principles:

* Pay reasonably and adequately for quality care for individuals
* Encourage cost-effective supports and services and promote efficiencies
* Be transparent and administratively efficient; be predictable and facilitate timely payments
* Encourage supports and services in the appropriate (least restrictive) setting; ensure adequacy of alternative settings; encourage service portability; promote service innovation
* Update methodology periodically and when necessary; promote service innovation
* Provide a good pricing foundation for transition to Managed Care
* Include a transition that provides a smooth shift from current rates to the proposed pricing; ensure system stability
* Comply with Federal Medicaid rules, and
* Be consistent with available resources, budget constraints and transformation goals

The rate changes being proposed in this a Waiver amendment fails to follow these principles. There has been a lack of stakeholder involvement in the development of these changes. The changes are being proposed in order to allow OPWDD to fund state mandated minimum wage increases and a four percent increase in wages for direct support and clinical staff, which had previously been promised by the Executive and enacted by the Legislature as part of the FY2020 budget process, without any increase in overall state support for the non-profit providers, who provide nearly 85 percent of the service delivery to individuals with I/DD. The proposed change in the rate methodology mid-cycle is the opposite of the predictability the OPWDD Methodology Transformation was intended to provide.

DOH and OPWDD currently fail to issue timely rebased rates, resulting in significant periods of underpayments and overpayments to providers billing based upon a previous rate cycle. This causes massive disruption in the financial affairs of providers, who are forced to address significant revenue shortfalls as the result of recoupment claw-backs with no time to plan and reducing the opportunities to identify and implement efficiencies in order to live within these new rates of payments. These proposed mid-cycle rate methodology changes merely exacerbate the problem, cause system instability, are not predictable and fail to support the efficient delivery of services.

The Legislature approved salary enhancements for direct care and clinical staff working in OPWDD residential programs – one increase to be implemented on January 1, 2020, and the second on April 1, 2020. Neither has been implemented as of this date but remain “under review” with the Division of Budget, further destabilizing providers, who have already provided these pay increases in many instances.

State operated programs are not subject to these rate reductions. DDAWNY continues to object to two different rate methodologies in New York, one for state-operated service delivery, which includes a yearly trend factor and one for voluntary-operated service delivery, which has not seen a trend in nearly a decade. Voluntary providers compete for the same workforce and provide the same supports and services as the state provides using its employees. There is a fundamental conflict of interest where OPWDD can propose funding reductions to CMS for the voluntary sector and not propose the same funding changes for its own employees.

The two-year impact of these rate reductions eviscerates the effort to provide Direct Support Professional (DSPs) with a living wage, are unreasonable and will only lead to further system instability, staff turnover, and will not improve the quality of services in the community. Indeed combining the proposed changes included in the enacted FY21 state budget, this waiver amendment and the announced Medicaid state plan amendments (SPA) impacting providers of ICF/DD services and the seven CCOs providing health home services, will save the state $49 million All Funds in FY21 and $188 million All Funds annually thereafter.

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| **OPWDD FY21 & FY22 ATL Spending** | | | | |
| In Millions | **SFY 2021** | | **SFY 2022** | |
|  | State Funds | All Funds | State Funds | All  Funds |
| SPA - Health Home Rate Cut | 30 | 60 | 40 | 80 |
| ATL - Supplemental R&BD | 10 | 10 | 10 | 10 |
| SPA- ICF Vacancy & Admin | 7.6 | 15.2 | 15.2 | 30.4 |
| HSBC- Supervised Res Vacancy & Com Hab | 51.9 | 103.8 | 103.8 | 207.6 |
|  |  |  |  |  |
| Savings | 99.5 | 189 | 169 | 328 |
|  |  |  |  |  |
| SPA - bFair 1/1/20 & 4/1/20 DSP & Clinic | (70) | (140) | (70) | (140) |
|  |  |  |  |  |
| Net State Savings | 30 | 49 | 99 | 188 |
|  |  |  |  |  |

Now is not the time for DOH and OPWDD to impose these cuts. In the midst of the COVID-19 pandemic, OPWDD voluntary not-for-profit service providers, especially residential providers operating congregate care IRAs, ICFs, and community residences are faced with unprecedented challenges. Faced with a global pandemic, voluntary providers have gone to heroic efforts to keep the over 29,000 individuals in these certified settings safe and healthy. The proposed cuts would result in a reduction in reimbursement by as much as 7.5% for certain residential programs with significant vacancies, including vacancies due to deaths from COVID-19.

The OPWDD provider community has already incurred significant hardships in connection with the COVID-19 public health emergency. Providers have experienced challenges with access to testing, staffing vacancies due to illness and family obligations, and shortages of PPE. Agencies have had to scramble to obtain PPE from private suppliers with absolutely no financial assistance and very little support from the state. Providers have been forced to develop contingency plans for quarantine and isolation in their residential programs without any state operational or financial support. Residential programs were left to finance the cost of the emergency on their own, without any financial support from the state to meet the increased costs of responding to the impact of the emergency.

Instead of making cuts during an already vulnerable time, New York State should be focused on working towards a slow and steady return to pre-COVID service delivery without jeopardizing the precarious financial position of so many voluntary agencies. The public health crisis is far from over and public health officials are anticipating a second wave or additional surges in the fall and winter.

The proposed cuts will severely limit funding for individuals simply because they require hospitalization due to medical or psychiatric illness or choose to take a therapeutic leave to spend time with family members. It is nothing less than discrimination against individuals with I/DD to eliminate the Occupancy Factor and cut reimbursement during hospitalizations, needed placement in a rehabilitation facility, or during family visits. Under the proposed cuts, if an IRA or ICF resident receives health care in another setting, their placement is reserved for them after their stay, and the rate for their care is reduced to 50% of the customary daily rate. The proposed cuts represent disparate treatment for individuals with serious medical or psychiatric conditions that directly impacts the level of services that can be provided.

The rationale offered by OPWDD for these cuts is that if an individual is not physically in his or her residence, there is no reason for the residential provider to be paid in full during such absences since the provider incurs no costs for that individual. However, this claim is invalid, and any claimed savings are entirely illusory. First, 80% of the cost of residential programs is salary paid to direct care staff, clinical staff and residence supervisors. These costs for direct care staffing are unaffected – and certainly can’t be reduced – simply because one resident of a six- or seven-person IRA is out of the house. Staff is provided around the clock usually with three 8-hour shifts per day. If a resident is in the hospital, a direct care staff member simply can’t be placed on unpaid leave until the hospital stay is over.

The absence of a single resident does not in any way reduce the need for a full complement of staff to provide for the needs and ensure the health and safety of the rest of the residents. To the contrary, when a resident is admitted to the hospital, staff are in most cases assigned to provide coverage, advocate for the individual, interface and consult with hospital staff, and ensure that the individual’s needs are met. Both OPWDD and DOH have issued guidance on the requirements for hospitalization coverage by OPWDD certified residential facility staff when an individual is hospitalized and the appropriate role of OPWDD program staff in providing companionship services and facilitating communication between an individual with I/DD and hospital staff[[2]](#footnote-2). These requirements actually result in more staff time and increased staffing costs, not the opposite.

Similarly, if a resident goes home with their family for the weekend or goes on vacation with their family, staffing needs for the rest of the IRA or ICF residents remain the same. Since OPWDD still runs its own certified residential programs, it well knows that the absence of one resident has no impact on the staffing needs in a residence and that a cut of 50% in reimbursement leaves the residence underfunded.

In most cases extended vacancies are the result of necessary hospitalizations. In the I/DD service system, many people with significant medical issues often require extended periods of hospitalization due to complicating behavioral factors or co-morbidities. In addition, some individuals have significant mental health issues that may result in the need for extended periods of inpatient psychiatric care due to behavioral issues. In both instances, it would not be unusual for a resident to be admitted to a hospital for weeks or months at a time. Under proposed amendment, providers are mandated to keep residential slots open and unfilled throughout the entire hospital stay or other absence from the residence. This is the opposite of the rule for nursing homes, where after two weeks vacant beds can be filled with new residents. During long hospital stays, agencies will have insufficient funding to pay for mandatory staffing levels.

The proposed additional cuts to the vacancy rate constitute discrimination against service recipients who have serious medical and/or psychiatric problems. Reduction in funding during extended hospital stays is an example of discrimination in funding for these individuals due to the very nature of their disability. Reduced funding hurts the individual in the hospital, the remaining residents, the provider supporting these individuals and the entire system.

The State’s proposal to cut funding when residents visit family members will act as a disincentive for community integration goals fundamental to the HCBS waiver.

14 NYCRR 641-1.2(p) defines “Occupancy factor” as follows:

*“an adjustment made prospectively at the beginning of the applicable rate year, based upon the previous years’ experience. Such adjustment shall be provider specific and shall be the lower of the provider’s actual vacancy or five percent.”*

The proposed amendment would eliminate the use of this occupancy factor in rate setting for supervised Residential Habilitation. Currently this adjustment to the daily rate of a Voluntary Agency is used to account for days when Medicaid billing cannot occur because an individual has passed away or moved to another setting. Elimination of this occupancy factor will act as a disincentive for seeking to move individuals into less costly Supportive Residential Habilitation settings and non-certified supportive apartment settings. The loss of the factor will lead to the reduction in the number of Supervised Residential beds as providers will seek to maximize the use of available beds and limit losses due to vacancies.

The elimination of the occupancy factor will reduce the availability of certified bed capacity for individuals seeking to leave institutional settings, especially individuals currently residing in 7-15 person ICF/DD institutions. CMS has sought to reduce the number of individuals in these larger institutional beds, yet as of the end of FFY 2017 4700 individuals still resided in voluntary operated ICF/DD beds, including nearly 3400 in 7-15 person capacity ICF/DDs.

Using its Protocol for Certified Residential Opportunities (CRO) process OPWDD determines who can be offered a certified residential opportunity. OPWDD currently fails to refer, on a timely basis, individuals most appropriate for certain supervised residential beds. Elimination of the occupancy factor will force provider agencies to offer vacant beds to individuals who may not be appropriate based upon a truly person-centered planning process. For example, individuals with a forensic background, including SORA classified individuals or those with severe behavioral issues, including fire starting behaviors may be inappropriately placed due to fiscal considerations.

DDAWNY strongly objects to the elimination of the occupancy factor which was an important component of the OPWDD Methodology Transformation and the movement from a monthly payment structure to a daily payment structure for these services. If OPWDD and DOH wish to reform the rate methodology for residential habilitation, they need to address the reform in a holistic manner, with broad stakeholder involvement, similar to the 2013 -2015 process, not piecemeal, solely addressing perceived budget challenges and to the detriment of a truly person-centered process of service delivery.

DDAWNY appreciates the opportunity to comment on the amendments being proposed to the current 1915(c) OPWDD Comprehensive Home and Community Based Services (HCBS) Waiver (NY.0238-Amendment 03) for the period beginning October 1, 2020 and continues to work as a partner with OPWDD and other State and Federal authorities to improve the lives of individuals with Developmental Disabilities, their families and their circle of supports.

Respectfully Submitted

DDAWNY, the Developmental Disability Alliance of Western New York

John R. Drexelius, Jr.

Government Relations Counsel

PO Box 141

Buffalo, NY 14223

716.316.7552

jrdrexelius@gmail.com

1. CMS 11-EW-00234/2, Attachment H of Special Terms and Conditions (STC) for New York’s Federal-State Health Reform Partnership Section 1115(a) Medicaid Demonstration retrieved at:

   <https://www.health.ny.gov/health_care/managed_care/appextension/special_terms_and_conditions_04_2013.htm> [↑](#footnote-ref-1)
2. OPWDD Health Care Hospital Coverage Guidelines, May 24, 2006; DOH DAL Role of OPWDD staff in hospital setting, June 6, 2014 [↑](#footnote-ref-2)