RCPA
REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

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On behalf of our members, RCPA would like to offer the following comments with regard to the proposed Selective Contracting 1915(b)(4) Waiver.

Our members support the ideal of assuring quality services for individuals with ID/A that are integrated and person centered, enabling individuals to experience more independence and choices in their lives. Additionally, we support limiting the provider pool to only those providers that are able to demonstrate quality service provision.

RCPA wants to support this program for two reasons. First, any initiative by ODP that focuses on improving quality in the system is something we all should support. Second, alternative reimbursement strategies with enhanced rates and additional funding based on quality and outcomes is certainly more innovative and progressive than traditional fee-for-service. It is time for the IDD system to move toward reimbursement policies that reward providers who are progressive in their service provision.

We are, however, concerned about the speed with which this incredibly complex systemic change is proposed to occur, and the amount of performance standards and measures proposed in this plan.

The quick movement of the process is concerning for a few reasons. The most striking concern is the need for additional education of individuals and families who will be impacted by these changes. We believe that many people are still unaware of the proposed implementation, and recommend that more information be shared widely with families and individuals to allow for additional feedback.

Additionally, the intense schedule is putting residential providers in the position of taking on additional responsibilities with little notice, during a time when agencies are experiencing serious staffing shortages, and resources are stretched thin. We are entering the summer season when staff typically enjoy some vacation time, and throughout the next two months, providers will be required to attend four mandatory webinars, participate in annual QA&I, collect data which at this moment is undefined, and develop a strategic plan for their organizations in order to prepare for their desired provider tier. All of this while continuing with the normal rhythm of operations.

The proposed plan will require providers to report data for 12 defined performance standards, with up to 83 measures. Many providers are not yet prepared with reporting systems to enable the collection of this data without a great deal of administrative work. A longer preparation time to develop internal data collection systems would be very helpful for the successful transition to this model. Additionally, the plan for ODP to use data from 2023 to evaluate providers when the standards were not defined/known to providers puts them at a disadvantage. At this point, they can't change retroactively, and the initial assigned level will be in effect for 18 months.

Furthermore, the expectation that providers demonstrate100% compliance with the proposed measures in order to reach a preferred tier is very challenging, and overly limiting. This means that a provider who meets all but even one area would be prevented from moving up for 18 months. If providers meet a substantial number of the standards, there should be some flexibility for reaching the different tiers, such as accepting attestations that they will work toward meeting the standard(s) that they do not yet meet. Several of the new standards will require significant time and financial investment to implement effectively. An attestation coupled with evidence of progress by providers is a recommended alternative

to a 100% compliance requirement. This would afford both providers and ODP the flexibility to meet the objectives without eliminating some high quality options for individuals seeking service.

We are concerned that the design of the Performance-Based Contracting plan may result in some unintended consequences. It is clear that the structure of the plan will drive individuals to more independent living arrangements, and competitive integrated employment. While these are goals that we believe everyone strives for, the implementation of the plan may inadvertently be taking away two key values that the Everyday Lives principle is founded on – those being choice and control.

Providers will be forced to implement practices that may be contrary to those very values, but instead promote those philosophies that ODP has determined to be best for individuals they serve. In essence, providers will be pushing the agenda of ODP, rather than a person-centered plan that should be our philosophy. While providers should be encouraging individuals to be as independent as possible including where they live, and where they work, we also need to keep in mind that not every person is interested in changing their current job or day activities, or leave a home that they have lived in for many years, in which they feel secure and happy.

Use of technology is also a very personal decision, and while many individuals are happy to utilize whatever technology is available, some are very protective of their privacy and may not be open to utilizing much technology. We need to always be cognizant of individual choice regarding how and where they receive services.

ODP has shared the expectation that a majority of providers may be in the Primary tier, at least for the first 18 months. This will result in very limited options for new referrals who are seeking residential services, as it has been recognized that many of those entering the service system are anticipated to have complex needs, and presumably would fall into Needs Group 4 or above. We recommend that there be an exception process where an individual could choose to receive services from a Primary provider if that provider is prepared to meet their needs.

Furthermore, ODP has consistently messaged its intent to protect small providers during its transition to PBC and to support their viability in the new system. The number of individuals served should not preclude a provider from attaining a Select or Clinically Enhanced tier if they are able to meet the identified performance standards. If small providers (serving 10 people or less) are restricted to the Primary tier, being limited to accepting only NG level 1–3, this will have a detrimental impact on their financial ability to remain in service. The challenge for small providers to meet the additional expenses to become a Select provider will already present a hardship that will be made worse with lower NG level individuals.

We understand that tier assignments will be made by the performance of each organization by MPI number. This could mean that for a large provider who has multiple MPIs, that part of their overall organization could be in a Select tier, while other parts are Primary, or even Conditional. How will that impact the overall functioning of this model? Another possible scenario that could pose a challenge is in the case of an organization merging with another who is currently in a different tier. How will that impact the tier assignment of the organization?

The Residential Provider Agreement has been proposed to be published in June and providers are expected to sign the agreement by the end of the month. The public comment period doesn't close until June 4. This poses a concern, since public comment should be considered prior to an agreement being issued for use. We recommend that the due date for a signed contract be delayed, allowing for adequate review time of the comments received from the public.

Residential Pay for Performance is proposed for providers who meet or exceed the corresponding performance targets in the areas of staff credentialing, employment of individuals served, and reporting on the use of technology. More detailed information is needed about how this part of the waiver will be administered. Must a provider meet or exceed each of these areas, or can a P4P be made for reaching one of these target areas? Providers need more specific information about P4P criteria to best prepare to meet changing expectations.

We recommend that:

- Fewer measurements be utilized for the initial six months; for example, providers would need to meet 10 of the 12 standards in order to be assigned the Select or Enhanced tier.
- All providers be assigned the Primary tier (or Conditional as appropriate) for the first six months and move to various tiers in July 2025.
- Providers be permitted to “attest to” a plan to meet the necessary standards within the first six months.

Review of Proposed Performance Standards Outlined in Appendix A

Continuum of Services:
The first performance standard which requires select providers to provide at least two of the three listed services during the review period poses the following questions/concerns.

If a provider is being evaluated on past performance (2023), this will eliminate the opportunity for providers who have recently expanded their service option in the past six months or are in the process of developing additional services.

During public comment, a question was asked if provision of unlicensed Lifesharing service would count for one of the two services. We recommend that this service be considered a qualifying service, not limiting that option to only licensed Lifesharing.

We believe that Respite services should also be considered one of the acceptable services offered that qualifies as part of the continuum of services. Respite is a very valuable service that can help support individuals and families who are in need of short term services, and also can help increase an individual’s independence as they experience life away from their family home. Respite services often serve as a transition to a more independent setting.

To the extent that otherwise qualified providers capable of demonstrating current compliance are being excluded from tier assignments, except for failing to retrospectively meet a standard that did not previously exist, it is recommended that ODP develop a reasonable and equitable exception process to allow these providers to qualify for Select or Clinically enhanced tiers, and to accept new referrals from NG categories for which they have a proven track record. If providers who are in this situation may have open beds in the future, but are not able to accept new admissions, this seems contradictory to meeting the needs of individuals who are on the waiting list.

Providers who currently offer these services and seek to attain a Clinically Enhanced tier level, but do not currently meet these criteria, would be permanently disqualified from attaining the Clinically Enhanced tier. We recommend that ODP communicate whether or not this is its current intent and clarify its position regarding providers that do not meet these criteria. We further recommend an exception process for those providers wishing to pursue Clinically Enhanced status to qualify for new referrals.

Clarity is also needed regarding referrals to Select and Clinically Enhanced providers. Will these providers also be able to receive referrals for NG1 through NG3? Or will they be restricted to serving higher needs groups?

Limiting the choice of providers for individuals by their SIS scores is problematic. Teams continue to report that in many cases the SIS score and Needs Level assigned to individuals are not accurate and are not reflective of actual needs. This has been very troublesome for providers who are supporting more intensive needs than what their reimbursement covers, due to inaccurate SIS scores (and reducing services for those individuals in many cases would be considered neglectful, placing individuals in danger, but appeals from providers have been unsuccessful). The current experience in the field is that many of these scores are not reflective of actual service needs. If this continues to be true, it is quite possible that individuals with more intensive needs may be directed to Primary providers who will not have the proper financial resources to meet those needs.

Using this tool in the current manner continues to pose a serious problem that needs to be addressed.

Workforce Standards:

Our members are in support of advancing staff skills through credentialing. We do share concerns about the complexity, time commitment, and expense involved with the NADSP credentialing process. Many of our members have adopted this credentialing platform already for their employees and have mixed reviews.

NADSP requires providers to have a minimum of 25 staff employed/enrolled, which places small providers at a disadvantage. It is also costly for providers to contract with NADSP. We recommend that ODP contract with NADSP and allow providers to access the credentialing service through ODP. This would be a more economical situation, particularly since the staff who are earning accreditation are not required to stay with the employer who supported them through the process, as it is a “portable” accreditation.

Providers are reporting that staff who speak English as a second language have additional challenges with becoming credentialed through NADSP, due to the writing skills needed. It would be helpful to explore an alternative way for those employees to express their experiences. One of the measurements listed is the requirement to offer training to staff that is relevant to the employee’s own culture and language. It would be helpful if ODP courses would also be adapted in this manner. For example, the current Medication Administration course is especially challenging to those who primarily speak a different language. In fact, some of the questions on the current test will be marked as wrong if the punctuation in the sentence is not correct. And some questions have two correct answers, but the student is expected to choose the “best” correct answer. These details in the test are not adapted for those who have language differences.

Supporting Individuals with Complex Needs:

Providers will need to demonstrate the use of a professionally recognized and ODP approved comprehensive assessment, and implement follow through. Could ODP provide examples of what assessments would be accepted?

Clinically Enhanced providers will need to meet a 1:10 minimum ratio of behavioral/mental health clinical staff to individuals served. How is this clinical staff defined? For an agency that offers a full range of services, including Clinically Enhanced, does this apply to individuals served by an agency in less intense services? For example, if an agency provides Clinically Enhanced services to 50 people, and Supported living to another 50 individuals, could the ratio be based upon the number of individuals in the Clinically Enhanced services, or would all 100 individuals be counted in the ratio? If that is the case, it will be very difficult for providers to meet the required ratio, and it would not be clinically necessary.

The proposed requirement for the population served in Clinically Enhanced services, 4.5 Needs Level <u>and</u> HCL of 3.5, is too restrictive. Providers who currently are providing services to those who have complex needs report that while the average Needs Level is 4.5 or higher, their HCL level is not necessarily high as well, due to preventative measures that have been successful. This is unnecessarily limiting to who can be served by providers who wish to be in the Clinically Enhanced tier. By being too prescriptive in these definitions, there will be an unintended consequence of limiting choices for people whose needs do not fit those specific requirements.

For Clinically Enhanced staff, providers will be required to provide documentation of intensive, specialized training relative to individual diagnosis (Prader-Willi Syndrome, Fetal Alcohol Syndrome, ASD, Borderline Personality Disorder, Pica). Please clarify if the trainings are intended to be specific to the population that a particular provider serves, or are the staff required to have specialized training in all of the listed areas?

Referral and Discharge Practices:

While it is reasonable to anticipate that new referrals’ service initiation starts on average within 90 days, we would recommend that a longer period of time be anticipated when a provider is opening a new

home/service, as that process can take a longer time — some circumstances of which a provider has little to no control.

We have addressed the concern regarding service based upon Needs Group previously in these comments. We believe there are many challenges with that policy, including preventing serving individuals who are on the waiting list.

Data Management:

It would be helpful if ODP would outline the specific functionality/capability providers should be seeking in an Electronic Health Record to help with making decisions moving forward.

Risk Management:

Consideration will need to be given to providers who are not able to close incidents due to factors out of their control. For example, providers may complete their information for an incident within the required time frame, but the incident is held at the county or regional level, and disapproved after the 30 days, requiring more action on the part of the provider. If providers are measured for compliance, then the entities reviewing the reports must also be held accountable for timely review and processing of incidents.

Employment:

Residential providers should not be measured based on the number of people they serve who have competitive integrated employment. While a residential provider can certainly encourage and support these efforts, it is not the job of residential providers to find and place individuals, and support them in employment settings. Employment is a discrete service, and there are providers specifically to do this job.

It is not reasonable to hold residential staff accountable for the results of a service that they are not providing; employment providers should be accountable for those services.

We recommend that the “working age” be adjusted based upon the individual’s specific circumstances. An individual who has been working for many years or attending a day service and is very happy with their decision should not be forced to leave. Additionally, “acuity” needs to be defined.

This measure puts providers who serve an older population, people not interested in working, or people with medical or behavioral challenges, at a disadvantage. Residential providers will be in a position of pressuring individuals to do something that they may choose not to do. It is important to reflect on how this aligns with the primary philosophy of Everyday Lives – choice.

Use of Remote Technology:

Technological supports offer great options to increase independence, and help providers in their efforts to deliver quality services. We need to be cautious that individuals’ choices should always be respected, and rather than measuring how many individuals served are using remote technology, perhaps we should be measuring how many individuals were offered use of technology. Or how has the residential provider educated the individual and family about the opportunities available through use of technology.

Community Integration:

While we understand that it is important for providers to assure follow through with HRST recommendations, and assure education and wellness activities are offered, we are puzzled why the measure states that providers “create and conduct” wellness programs. Wouldn’t it be more logical, particularly since this falls under community integration, for providers to support individuals utilizing community resources to meet these needs unless the individual required specialized supports?

In conclusion, we are in favor of the movement toward higher quality services, and believe that paying providers who perform above basic standards should be rewarded and incentivized to meet quality requirements. We have concerns with the speed at which this transformation is being proposed for implementation, and believe that more time is needed for careful consideration of the details of the plan,

including those we have discussed in these comments. Families and individuals need to be educated and given time for feedback to ensure full understanding of the impact of these changes. This transformation will take much time and resources for providers to implement, including new administrative positions and data system in order to collect data, etc. We recommend that caution be used when determining just how many standards and measures are required, as these additional needs may ultimately reduce the amount of funds available to build up our most needed resource, direct support staff.

Thank you for the opportunity to share our thoughts.

Sincerely,

Carol Ferenz
Director, IDD Division