

**Assessment of Public Comment**  
**Proposed 14 NYCRR Subpart 641-1 – Rate Setting for IRA/CR**  
**Residential Habilitation and Day Habilitation**

OPWDD received numerous comments from providers, provider associations and a consultant. Below is the assessment of the comments received and OPWDD's responses. Several of the responses note in parentheses that the regulations have been amended in response to the comment. In these responses, OPWDD is referring to the emergency/proposed amendments to Subpart 641-1 that were adopted and went into effect the same day the regulations proposed in April were adopted. Because these amendments were not finalized when the summary of the assessment of public comment was submitted to the Department of State for publication, the summary does not mention these amendments.

**1. Values for Budget Neutrality Adjustment and Regional Averages**

COMMENTS: In addition to describing the calculation of the Budget Neutrality Adjustment, the actual value of the adjustment should be published as part of the regulation in order for providers to be able to calculate its rate from reading the regulations. Also, the Budget Neutrality Adjustment is permanently fixed because it is calculated using the sum of all provider rate sheets "in effect on June thirtieth, two thousand fourteen." This language should be modified to indicate that this value will be revised annually to include the value of services expansion and other funding increases added after June 30, 2014.

The regulations refer to various "regional averages" for various components of the operating rate and the method for calculating such "regional averages" and the resulting values should be published as part of the regulations in order for providers to be able to calculate its rate from reading the regulation. The proposed regulation as written does not provide sufficient transparency. A provider cannot determine its own rate based upon the information provided in the regulation. The lack of detail, and lack of a process to review the state's methodology for creating regional averages all underscore the serious shortcomings in the rates.

RESPONSE: OPWDD and the Department of Health (DOH) have decided that no change to the regulation is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation. The regional averages will be posted on the DOH website and therefore will be accessible to providers.

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**2. Implementation Date**

COMMENT: Rates should not be implemented July 1, 2014 because providers have not yet been provided with their rates. It is unreasonable to impose new rates effective July 1, when providers have not seen their new rates. The lack of timely notice of rates does not allow for adequate time to plan. Providers have yet to see what the final rates will be and the implementation date is less than a month away.

RESPONSE: The methodology will be implemented on July 1, 2014.

**3. State operated providers**

COMMENT: There is no rational basis to discriminate between state operated and voluntary operated providers of residential and day habilitation in the creation of rates. Voluntary providers compete for the same workforce and provide the same supports and services as the state, yet the rate methodology does not include the cost of state operated residential and day habilitation programs in the development of regional rates.

RESPONSE: The methodology will not be changed to include State operated programs in the development of regional rates.

**4. DOH Regions**

COMMENT: The use of DOH regions to align providers is predicated on the anticipated move to managed care. However, since the predominance of funding for people with developmental disabilities is in fact related to OPWDD funded services and not health or other long term care services, we question not using regions that are driven by OPWDD services.

RESPONSE: Although DOH regions are slightly different from OPWDD regions, DOH feels that the regions are closely aligned and are appropriate for use in the methodology. The regions were chosen to align with long term managed care regions currently being used by DOH.

COMMENT: The use of DOH regions fails to appropriately group similar wage and cost structures and economies on a rational basis. The creation of upstate urban and rural groupings fails to address the very real regional cost differences which exist across the state and the groupings blend urban and rural counties in ways that are irrational. The use of these regional groupings combined with the use of average costs of care without an acuity

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adjustment using a valid assessment tool leads to rates which are not economic, efficient or likely to lead to quality outcomes.

RESPONSE: OPWDD and DOH consider that the DOH regions are appropriate for use in this methodology.

### **5. Region 1 Providers**

COMMENT: The regulation discriminates against Region One providers. Based upon data that has been released, OPWDD Region One providers will see overall losses of \$6.8 million under rate rationalization or 58% of the total statewide savings arising from the new rate rationalization methodology. This takes into consideration both winners and losers. The seventeen counties of OPWDD Region One bear a disproportionate share of the cost of rate rationalization. If Region One providers provided approximately the same percentage of services, the region's loss under the rate methodology might be understandable. It is not. Region One voluntary providers currently represents only 9% of the total ICFs/DD operated by the voluntary sector statewide. Region One providers only provide 19% of statewide certified housing, including ICFs and provide 15% of all day habilitation units billed statewide.

RESPONSE: DOH and OPWDD believe the methodology does not discriminate against any group of providers.

### **6. CFR Data**

COMMENT: Even though independent auditors certify the CFRs, OPWDD internal auditors have expressed concerns that there are misallocations of costs inconsistent with CFR guidelines. OPWDD has completed random audits and has concluded that there is substantial misreporting of costs by providers. These findings should have triggered a wide scale review of all CFRs, but to date the audits have been limited to providers who filed rate appeals. There is no indication that the misallocation issue is limited to providers that filed rate appeals, and as such there is a strong likelihood that the entire database is flawed. In spite of this, OPWDD and DOH are relying on the CFRs to reimburse residential and day program providers.

RESPONSE: OPWDD and DOH are not changing the methodology in response to this comment.

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**7. DDP, E-Scores and Statewide Average Direct Hours Per Provider**

COMMENTS: The Developmental Disabilities Profile (DDP) has not been validated, was never designed as a tool to allocate direct care hours among providers serving individuals with developmental disabilities, and lacks inter-rater reliability. DDP scores are out of date and are updated inconsistently. There are no specific requirements, qualifications or training for staff who conduct the assessment. The DDP is not a reliable tool for determining acuity due to inconsistencies with who completes the instrument and how it is completed. Since DDP forms are completed by providers who have been aware for a long period of time that rates would be created from their use, they are not accurate representations of the acuity of individuals receiving services.

The regulation should be amended to allow all IRA providers to be funded for the actual direct support hours that they actually provided in the same manner as is proposed for ICFs/DD and day habilitation programs. Also, OPWDD should await implementation of the new Coordinated Assessment System (CAS) assessment tool next year.

The DDP is not a valid tool to measure acuity. This tool was designed and is used to register needs. The DDP is completed by any number of people, including service coordinators, direct support staff, clinical staff and family members. People completing the DDP have had no special training or credentialing to administer the tool objectively. Therefore, the outcome of the DDP are subjective and not a valid objective recording of need. If the DDP is the tool being used, the decision to not include the medical component score from the DDP discounts the medical and health related needs of the individuals. A Health Department representative shared, during a webinar, that they used the Adaptive Score and the Behavior Score but not the Medical component score of the DDP in calculating rates. When questioned why the medical needs section was not used, the response was that there was no correlation so they didn't use it. The Health Department representative shared that they did allow for the medical clinical needs and cost by allowing RN and LPN cost as a pass through. The issue is that the Medical section of the DDP is where the medical needs of the individual are recorded (medical diagnosis, medical conditions requiring staff to provide treatments- such as bi pap or C-pap procedures, seizure diagnosis- which may require additional supervision levels by direct support staff, medications the person is on and medication administration needs- which determines if staffing is required to administer medication including extensive tube feedings, and loss of program time due to medical conditions -which would indicate if the person needs additional staffing to supervise them when they are home and not at their day habilitation services, all of these needs can affect staffing levels). Direct support staff, under the Nurse Practice Act, complete nursing task.

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Direct support salaries are not a pass through, so having the RN salary and LPN salaries pass through doesn't reflect the total costs of providing for the medical/physical health needs of the person, i.e. medication administration, tube feedings, and application of various other medical treatments that affect the staffing needs of a home. Not including the medical information in the methodology is not considering the total needs of the individual and discounts the staffing that is needed to meet the medical needs of the individuals.

OPWDD has indicated grave concern over the reliability of the DDP data. Since these forms are completed by providers who have been aware for a long period of time that rates would be created from their use, they are not accurate representations of client acuity. OPWDD in acknowledgement of this concern decided to utilize the interRAI Assessment Suite and the Coordinated Assessment System to provide more accurate information. In spite of this acknowledgement by OPWDD, an unreliable database is being used for acuity.

The Commissioner of OPWDD stated recently in Buffalo, that "the DDP is not an accurate measure of need", and she went on to share the new assessment system will be a tested, more reliable measure of need. If the Commissioner acknowledges the flaws in the DDP for measuring needs, why would OPWDD use the DDP and instead of delaying rate setting methodology change until the new assessment tool has been finalized, has been vetted, tested, and validated?

RESPONSE: DOH is confident in the results of a regression analysis utilizing DDP for the Supervised and Supportive IRAs, which yielded strong regression models with r-squared values between 30 and 40%. The findings for Day Habilitation and ICF yielded r-squared values below an acceptable level, and therefore were not used. Risk assessment tools currently used in acute care payment methodologies on average have lower r-squared values ranging between 15 percent and 30 percent.

COMMENT: There is no adjustment for acuity related to medical complexity of individuals being served. While DOH states there is no correlation between the medical DDP scores and staffing levels (which may be true as some agencies may be using LPNs on their clinical line to fill the same role that other agencies are using direct care staff for) there still needs to be some adjustment for medical complexities. If there is no way to reasonably adjust for medical acuity, then agencies should be provided their actual hours until a reasonable method can be developed. DOH has indicated that medical acuity is being taken into account based on the fact that actual clinical hours are being passed through to agencies and the use of the E-Score adjustment. However, clinical hours and emergency evacuation needs are not the only reflection of the level of care an individual

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with medical complexity may have. Additional staffing is necessary on overnights for administration of medications or supervision to maintain safety, and during day time hours for passing medications, for additional supervision to monitor complex medical needs and to accompany individuals to medical appointments which will be more frequent for someone with highly complex medical needs. Agencies that have consistently lived by a most integrated philosophy in supporting people throughout the aging process, as opposed to seeking support through a skilled nursing facility or other institutional setting, will feel the greatest impact.

RESPONSE: Since the methodology both uses an E-Score adjustment and includes all the clinical hours the provider reported, the methodology takes into account medical acuity of the individuals in the residence.

COMMENT: Each agency is being provided only 75% of their actual hours, per their CFR, plus 25% of the state average hours modified by acuity. This means that agencies are either losing hours that they are actually using to care for individuals or they are getting more hours than they presumably need to care for individuals. Our agency, as an example, is losing over 45,000 direct care hours from our reimbursement *even* though the methodology only represents 25% of the calculation. These are hours that were and still are actually used to provide support to the individuals we *serve*.

In the current financial environment, we should be able to conclude that agencies are not using more direct care hours than are required to both ensure health and safety and to provide high quality supports to individuals in the most integrated setting. For agencies like ours who will be taking a direct care staffing reduction it will make it *even* more challenging to comply with the new CMS waiver regulations that just went into effect this year.

Approximately 120 providers will receive revenue reductions for direct support hours that they actually provided, while 127 providers will receive increased funding for direct support staffing hours without any documentation that these additional hours are needed. The methodology will significantly reduce the financial support for direct support staff to a point below the level necessary to ensure the health and safety of service recipients.

This methodology is taking away more than a million hours of direct care staffing from agencies that are using them to support individuals with very complex medical needs and giving them to agencies that have demonstrated, based on CFR reporting, that they don't need them. This may force agencies to make difficult decisions that may result in the implementation of custodial care for our most medically frail individuals. Even worse, it

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could put individuals in potentially unsafe situations if staffing is not adequate to meet their needs.

RESPONSE: OPWDD and DOH consider that the use of acuity factors is appropriate.

COMMENT: The E-Score calculation is based upon subjective and ill defined factors and a tool which was never designed to measure appropriate staffing needs. The issue is that having a more fire safe home doesn't always equate to the level of staffing required. For example, a home may only need one on the overnight for fire evacuation purposes but a second staff is needed due assist with behaviors or because of the lifting and transferring needs of the individuals.

RESPONSE: OPWDD and DOH consider that the use of E-Scores and the calculation is appropriate.

COMMENT: The use of a regional average will reduce wages or slow wage growth for direct support workers, who are already poorly compensated.

RESPONSE: OPWDD and DOH consider that the use of regional averages is appropriate.

## **8. Facility Cost Component and State Wide Budget Neutrality Adjustment**

COMMENT: The regulation should state that this value of the Budget Neutrality Adjustment will be revised annually to include the value of services expansion and other funding increases added after June 30, 2014.

RESPONSE: OPWDD and DOH have decided that no change to the regulation is necessary at this time in response to the comment. However, the comment will be taken into consideration when subsequent amendments are made to the regulation.

COMMENT: The regulation proposes to take a provider's actual board costs and apply a budget neutrality factor that will in affect reduce each provider's board costs; then add in the approved room costs to generate adjusted total room and board costs. From this adjusted figure Supplemental Security Income (SSI) and the Supplemental Nutrition Assistance Program (SNAP) funding is subtracted to generate a net (reduced) room and board value. In a number of instances, the value of the combination of the SSI and SNAP benefits will exceed will exceed this net room and board value which will falsely result in "excess" SSI/SNAP benefits which can then be used to reduce a provider's residential habilitation rate funded under Medicaid. Meanwhile, the individuals who reside in IRA

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settings are not able to have their SSI/SNAP benefits fully utilized to first cover their actual room and board costs.

In doing the calculation in this manner it will result in the unintentional misuse of the SSI and the SNAP benefits of the people with developmental disabilities who live in these settings. Both of these Federal programs are designed for very specific purposes under federal law. According to Social Security's website, SSI provides cash to help aged, blind, and disabled people, who have little or no income, meet basic needs for food, clothing and shelter. Also, according to the NYS Office of Temporary Disability and Assistance, SNAP benefits can help low-income working people, seniors, the disabled and others feed themselves and their families.

The budget neutrality calculation should occur at the very end of the calculation when the State can decide how much of the true (actual) excess room and board costs over SSI/SNAP benefits it wants to supplement providers.

RESPONSE: OPWDD and DOH have decided that no change to the regulation is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation. (Note: OPWDD and DoH have amended the regulations to change the budget neutrality calculation.)

### **9. Capital Component**

COMMENT: The capital thresholds included in the proposed regulations are more than six years old (adopted April 1, 2008) and minimally should be made current. This issue is especially problematic for the downstate regions of the State where affordable housing continues to be a significant problem. There needs to be a provision for amendments to the cap and threshold values for capital acquisitions, new construction and leases to be updated on at least a periodic basis based upon an appropriate housing index. The State and the nonprofit providers have made significant investments in real property to support thousands of individuals yet there is no provision to exceed the threshold values:

- especially as homes are reviewed by OPWDD against fire safety guidelines that could require providers to make significant capital investments to meet code;
- for developing new homes that can satisfactorily meet the needs of individuals with significant challenging behaviors and/or medical issues; and
- in order to meet money follows the person goals which require 4 persons or less to live together.

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RESPONSE: OPWDD and DOH will not change the regulation at this time, but will consider the comment when subsequent amendments are made to the regulation.

COMMENT: The following three comments all pertain to property costs approved prior to July 1, 2014.

- The inclusion of language that “DOH may retroactively adjust the capital component” is problematic for providers whose capital cost has already been approved by OPWDD in that the draft regulation appear to permit DOH to reduce capital reimbursement approved under proposes to limit reimbursement at the lower of the amount Subpart 635-6 if it exceeds reimbursement under the new proposed regulations. The language in the proposed regulation needs to be amended as follows: “(i) General principles. Capital costs shall be included in the rate at the lower of the amount determined pursuant to Subpart 635-6 of this Title or thresholds as determined pursuant to subparagraph (iv) of this paragraph. *However, capital costs approved by OPWDD prior to July 1, 2014 through the formal prior property approval process shall only be subject to Subpart 635-6 of this Title....*”
- The language in “(ii) Initial rate” needs to be amended to make clear that the new regulations on capital costs only apply to new residential and day programs and that the new proposed capital cost rules do not apply to capital costs approved by OPWDD prior to July 1, 2014 and such capital costs shall only be subject to Subpart 635-6.
- OPWDD indicated in meetings with providers that there was no intention to alter or impact existing PPAs. Concern was expressed about the possible dire consequences of calling into questions that state's commitment to provide reimbursement under PPAs currently in effect. There was assurance from both OPWDD and DOH staff that existing PPAs would be honored as issued. Since there is no intention to affect current PPAs and we do not want to raise questions from lenders, bond holders, and DASNY about the validity of current PPAs, the regulations should contain language in each of the property sections to the effect that the property reimbursement section of new regulations only applies to PPAs issued on or after the July 1, 2014.

RESPONSE: OPWDD and DOH will not change the regulation at this time, but will consider the comment when subsequent amendments are made to the regulation.

(Note: OPWDD and DOH have amended the regulations to state that the capital cost thresholds only apply to PPAs issued on or after July 1, 2014.)

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COMMENT: In addition to the changes requested in the comments immediately above, another comment said that the language in the proposed regulation needs to be modified to state that DOH's ability to retroactively adjust the capital component is limited to adjustments made to *"reflect capital costs approved pursuant to Subpart 635-6 or pursuant to. . . [the capital component paragraph of the regulation]."*

RESPONSE: OPWDD and DOH will not change the regulation in response to this comment.

COMMENT: The short term interest time limit ("k") should be increased from 12 months to 18 months without limitation between acquisition or renovation phases given the delays in receiving prior property approvals as well the delays in the ability to obtain building permits from local municipalities.

RESPONSE: OPWDD and DOH are not changing the regulation at this time, but will take this comment into consideration.

## **10. Trend Factor**

COMMENT: The regulation states that "for years in which DOH does not update the base year, subject to the approval of the Director of the Budget, DOH may use a compounded trend factor to bring base year costs forward to the appropriate rate period". However, the regulation fails to describe the use of a trend factor when the base year is being updated.

RESPONSE: The language as stated is correct. Trend factors will not be applied in years in which the methodology is rebased.

## **11. Initial Period**

COMMENT: The definition of "initial period" (7/1/14- 12/31/14 for calendar year providers and 7/1/14-6/30/15 for fiscal year providers) is not needed, because rebasing will occur on 7/1/15 for all providers, minimal changes will occur on 1/1/15, and the first year of transition is 7/1/14-6/30/15 for all providers. In 641-1-6 (Transition Period and reimbursement), there is no reference to the "initial period" but rather to the "base operating rate" which as defined in 641-1.2(d) has a different meaning.

The "initial period" is defined as July 1, 2014 through December 31, 2014 for providers reporting on a calendar year basis or July 1, 2014 through June 30, 2015 for providers reporting on a fiscal year basis. However, in 641-1-6 (Transition Period and reimbursement), there is no reference to the "initial period" but rather to the "base operating rate" which as defined in 641-1.2(d) has a different meaning.

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RESPONSE: The “initial period” will be July 1, 2014 through June 30, 2015 and refers to the first year of operation under the new methodology, while the “base operating rate” refers to the reimbursement amount calculated by dividing the annual reimbursement by applicable annual units of service in effect on June 30, 2014. No change to the regulation is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation.

## **12. Appeals and Corrections to Rates**

COMMENT: There should be an appeal process, and a 90 day correction period from the beginning of the rate period for either provider or State error.

RESPONSE: DoH and OPWDD have decided that no change to the regulation is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation. (Note: OPWDD and DOH have amended the regulation to allow a 90 day correction period. OPWDD and DoH have not changed the regulations to provide for an appeal process.)

## **13. Template Funding**

COMMENT: Template funding should be addressed in the regulations.

RESPONSE: DOH and OPWDD have decided that no change to the regulation is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation. (Note: The regulation has been amended to address template funding.)

## **14. Therapeutic Leave Days**

COMMENT: Therapeutic leave days will be reimbursed at zero dollars to start and reimbursed after a period of time. This will have major cash flow implications on providers. It is our understanding that OPWDD and DOH plan to correct this through an emergency regulation, which will indicate that the provider will be reimbursed for therapeutic leave days at its residential habilitation rate starting July 1, 2014.

Finally, since reimbursement for therapeutic leave days will commence July 1, 2014, this section needs to be amended to exclude reference to therapeutic leave days.

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RESPONSE: DOH has made system changes in order to allow providers to be paid for therapeutic leave days as they are reported. With respect to the remainder of the comment, OPWDD and DOH have decided that no change to the regulations is necessary at this time in response to the comment. However, the comment will be taken under advisement for consideration when subsequent amendments are made to the regulation. (Note: The regulation has been amended to state that therapeutic leave days will be reimbursed at the appropriate residential habilitation rate.)

**15. Vacancy Days**

COMMENT: The last sentence in section 641-1.6(b)(3) needs to be amended as follows:  
“Providers will be paid for vacant bed days at seventy five percent of the daily operating rate as calculated pursuant to paragraph (1) of subdivision (c) of section 641-1.3 of this Subpart up to a maximum of *ninety consecutive vacancy days per vacancy*”.

RESPONSE: The vacant bed language is correct as written. The maximum allowable vacant bed days for the initial period will be limited to a maximum of ninety days per bed.