Ohio Provider Resource Association
Providing choice and quality care for people with developmental disabilities

January 14, 2010

OPRA Comments on CPT-Related Revisions to 5123:2-9-06 and 5123:2-13-07 as Proposed by ODODD December 31, 2009

Thank you for the opportunity to comment on the revisions to 5123:2-9-06 and 5123-2-13-07 being proposed by ODODD. We support open communication between the department and stakeholders on the revision of these important rules.

ODODD initially stated that the scope of these revisions was to accommodate the department's new cost projection tool (CPT) and the requirement that all county boards use the CPT by December 31, 2010. In a subsequent conversation, the department also cited an interest in "cleaning up the rules" with no substantive changes associated with their clean up. Our comments are aligned with the department's stated scope.

General Comments

We support the requirement that all county boards and providers use a standardized cost projection instrument developed by ODODD with stakeholder input. This will increase standardization, transparency and accountability across Ohio and may lead to efficiencies as well. We appreciate the department's unwavering support of provider access to this instrument, which will be critical to its success.

From OPRA's perspective and as we have communicated to the department, some of the revisions proposed by the department in these rules go beyond the stated scope of CPT implementation and rule clean up. Whether or not the expanded policy effect was intentional, it puts us and the other stakeholders in a difficult position. If the department chooses to continue with the currently proposed revisions, the stakeholders will need to decide whether or not to consider the entire rule open for discussion. Pursuit of

revisions beyond the stated scope could create public controversy at least and at worst will once again create division in our field.

We encourage the department to continue to work with stakeholders to narrow the scope of the revisions to the department's stated purposes. The opportunity for input already afforded to us is greatly appreciated, and we stand ready to work with you on rule revisions necessary to implement the CPT in a timely and efficient manner.

Major/Specific Concerns

5123:2-9-06 rule

1. Providers need to be ensured access to the CPT, not just the detail from the CPT. In every meeting with the department and other stakeholders, we have been assured that providers will be able to prepare versions/drafts of CPT's for the county boards to consider. We recommend the following revisions:
(B)(3) "…used by county board of developmental disabilities and providers to project the cost…".
(G)(1) "…developed by the department. The county board may rely upon a CPT completed by the individual's provider. On or before…"
(G)(7) Replace current language with: "The individual's provider will have access to the CPT including but not limited to the detail and summary information. At the request of the individual, other persons will have access to the detail and summary information in the CPT."

2. An individual's right to request a hearing is not contingent on the denial, reduction or termination being in their ISP, rather on receiving notice of such a change. We recommend deleting "in an ISP" in (E)(3).

3. (G)(6) is inaccurate. The CPT will not be used to "project cost" for individuals who are not on an IO or Level One waiver.

4. Our waiver reimbursement system is not an at-risk system and therefore providers have the right to ask for changes in the ISP whenever service patterns vary, not just those changes deemed to be "significant" by the

county board. Under this language, providers would be subject to losing thousands of dollars a year. We recommend deleting (G)(8).

5. H/PC and transportation provided when the individual is not present are not considered separate or distinct from these services provided when the individual is present and therefore not required to have the manner in which the waiver service is to be delivered specifically in ISP. (H)(8)(a) already requires that waiver service be "identified in an approved ISP" for reimbursement. We recommend deleting "in accordance with the ISP" in (H)(3) and (H)(6).

6. Improper payments language is in federal regulation, Ohio statute and ODJFS rule already, so the addition of any language is not needed in ODODD rule -certainly not for CPT implementation or clean up. This language does not include reference to ORC 5111.914 nor does it include mention of a provider's due process rights. We recommend deleting (I)(8).

7. As the single state Medicaid agency, ODJFS is required to have final authority for Ohio with respect to our HCBS waivers. We believe this is a important requirement that ensures Ohio's compliance with federal Medicaid regulations and protects the rights of Medicaid recipients. ODJFS does not need ODODD recommendation to exercise its authority. ODODD rules cannot weaken or subvert ODJFS's Medicaid authority. We recommend deleting ", based upon the recommendation of the department, " in (K).

8. ODJFS's authority to establish waiver rates is unnecessarily repeated specifically for on site/on call and not for other services. We recommend deleting the division labeled as (K)(d).

9. Why change "payment" to "reimbursement" throughout the rule? We prefer "payment" as it has no connotation of being cost based.

10. The rule is not clear on when requirements apply to Level One and IO versus when the requirements apply only to IO. We recommend a separate section on Level One, instead of trying to massage Level One language to fit in to the system designed for IO.

11. Page 9 of Appendix A deletes "counseling services" from social work/counseling services, whereas the IO waiver document includes those "licensed in the state of Ohio to provide professional counseling" and cites 4757:15-02, the scope of practice for an LPCC. We recommend leaving the service as "Social Work/Counseling Service".

Daily Billing Unit Rule

12. Same concern as in #1 above. We recommend the following revisions:
(B)(1) "…used by county board of developmental disabilities (county boards) and providers to project the cost…".
(D)(4) "…Administrative Code. The individual's provider will have access to the CPT including but not limited to the detail and summary information. At the request of the individual, other persons will have access to the detail and summary information in the CPT."

13. (B)(2) added language "in a manner that is most consistent with efficiency, economy, and quality of care". We recommend this language be deleted.

14. The definition of DRA in (B)(3) is incorrect. The DRA does not "project the cost" of waiver services. The DRA determines the allocation of cost among cohabitants sharing H/PC services with an HCBS waiver recipient(s).

15. Same concern as #3 above. We recommend deleting (D)(7)(a).

16. Same concern as #5. We recommend deleting (G)(2).

17. (H)(1) notwithstands sections of the '06 rule that require service unit rate adjustments for group size, provider type (agency/independent) and cost of doing business category. It also not withstands the section clarifying that H/PC may be delivered when the individual is not present. We recommend replacing the first sentence with language that clarifies the department's intention here. Is the department's intention to make it clear that ratios are not required to be tracked or billed?

18. There are two division H's. We recommend the division on Monitoring be division I.