**OPRA**

**DAY AND SUPPORTED EMPLOYMENT**

**REDESIGN REVIEW WORKGROUP**

As of May 19, 2015

**SUMMARY OF CONCERNS:**

* Annual cap for proposed services ICS and IPV is limiting to private providers who support individuals for more than 220 days per year
* Aggressive reduction in staff/individual ratio creates a dramatic increase in expense to providers and the need for more direct service employees with an existing issue with recruitment and retention
* Financial Impact to providers increases over 200%
* IPV service time limit creates a barrier to ensure person-centered planning and access to real vocational learning experiences
* Transportation needs to be addressed
* Use of “prevailing wage” is confusing and may be misleading
* AAI is not an appropriate tool to determine an individuals level of support needed in a community setting
* Need to address individuals support needs for those with intense medical, physical, and/or behavioral supports
* Ratio adjustments added to the base rates need to be similarly aligned with all acuities
* Staff qualifications should be waived for those currently providing similar supports prior to implementation date of the new services
* ICS rates should match the IPV rate since the staff qualifications remain the same and it takes the same level of support and oversight.

**CONCERNS**

* **Annual Cap**: Currently the proposed day and prevocational service cap is 1500 hours per year. With authorizations permitted to 31.25 hours of services for these two supports over a 48 week period, these numbers are based upon the county board schedule of 240 days of service per year. Private providers operate day services 260 days per year.
	+ **Suggestion**: Increase the cap to 1625 hours per year. 31.25 x 52
* **Ratio**: We completely understand the need to reduce the staff to individual ratio to ensure quality services while in the community, as well as safety. We do, however recognize that the proposed requirement of reducing this ratio in such an aggressive nature will create a predictable burden that will limit progress. Changing ADS, acuity A from a 1:12 ratio to the new ICS, acuity A at a 1:4 ratio will require 300% more staff than what we need to do the job today. Considering that we currently have a 47% turnover rate in direct care support positions and a continuous issue with FTE vacancies across Ohio, recruitment of qualified applicants remains a critical issue yet to be resolved.
	+ **Suggestion:** CMS guidance clearly states that the maximum group size cannot exceed 8 individuals. We feel that while a 1:8 ratio in the community can be challenging, but from experience, we know that providers aren’t taking 12 individuals out with one staff on a regular basis now. We believe that given the opportunity to manage our group sizes based on the activity and individual supports needed, we will be able to manage group sizes, as well as the need for such a large increase in staff.
* **Financial Impact**: While we support the smaller ratios among the acuities, it is imperative that the rates adequately fund the changes based upon the expectations in the definitions and the increase in expenses for needing more staff to complete these duties. In a comparison of existing ADS and Vocational Services to the newly proposed services, we observed great disparity between the revenue of the proposed rates to expenses, mainly due to the changes in the staff/individual ratio for all acuities.
	+ **Suggestion**:
		- Increase the staff to individual ratio (e.g. 1:4 to 1:8, both for ICS and IPV)
		- Increase the ICS rates to match the proposed IPV rates. Since the current rate methodology used to come up with this rate focuses only on staff qualifications and other ERE, there should be no reason to change the rate. By making the ratio change and keeping the rate as proposed (per person; per hour), this will give us an opportunity to test the new integrated services in a more manageable position than the current plan.
		- By increasing the ratio and matching ICS to IPV rates, keep the same per person, per hour rates
* **Integrated Prevocational Supports**: Integrated Prevocational Supports have a cap of 24 months. Upon review of the permitted services under this definition, we believe that the cap could be limiting people from accessing internships and other learning opportunities that are time limited. Some internship locations may only want someone for a couple hours per week. The cap restricts the number of actual hours of experience and skills building that a person can obtain if the overall time cannot exceed 24 months. While we appreciate the exceptions, it can be assumed that this much rigidity can reduce opportunities as well as the flexibility needed to ensure a plan is person-centered.
	+ **Suggestion**: Allow a person to receive Integrated Prevocational Supports based upon a total lifetime benefit of 3250 hours. 31.25 x 52 x 2. Providers would log hours and report this information to the SSA.
* **Transportation**: To ensure full community integration, transportation needs to be addressed. Current waiver rules under 5123: 2-9-18 has specific requirements that simply don’t align with the new ratio requirements under the new service definitions (e.g. passenger capacity of 9 or more for the per-trip rate). Access to available transportation needs to be evaluated in all areas of the state.
	+ **Suggestion**: Review the size of vehicle requirements for NMT per trip rate.
	+ **Suggestion**: Assess the impact that access to available transportation may have on the new integrated service definitions.
	+ **Suggestion**: Request that DODD form a special workgroup to assess, identify limitations and create viable solutions to the transportation issues that would be a barrier to full access to community participation as defined in the new services. This workgroup should be well-represented, including: private providers from both rural and urban settings, county boards and other pertinent contributors).
* **Prevailing Wage**: The use of “prevailing wage” is misleading and can be misunderstood. Prevailing wage under ORC 4115 is defined specifically for contractors and sub-contractors of skilled trades. This can be very confusing for job seekers, SSAs and providers.
	+ **Suggestion**: Change “prevailing wage” to “wages equally paid to PWOD in the same job/position with the same level of experience.”
* **Acuity Assessment**: Currently the AAI is not an adequate instrument to determine a person’s support needs in a community environment. Incorporate person-centered planning into the assessment basing acuity on a person’s real needs in the specific environment where he/she will receive the services and supports indicated in the ISP.
	+ **Suggestion**: We suggest that a special committee be formed promptly to review possible alternatives to the AAI or ID shortcomings with this assessment tool to make sure that it appropriately identifies the level of support needed to reflect the service requirements in the community.
* **Ratios**: We are specifically concerned about individuals with physical, medical and/or behavioral support needs. To safely and adequately support a person who has these very specific needs, it may not be possible to have one direct care staff assigned to two individuals (assuming Acuity C)
	+ **Suggestion:** We suggest that a ratio of 1:1 be considered for individuals with physical, medical and/or behavioral needs while in the community with a specific reimbursement rate for this group, including behavior and medical support add-ons to the rate. By doing so, this will enable providers to support all individuals, regardless of disability within the community.
* **Ratio Adjustments**: We appreciate the much needed ratio adjustment, however we don’t see the need for the difference between acuities since the level of overhead does not change based on acuity.
	+ **Suggestion:** Make the ratio adjustment for all acuities 15% above the base rate.
* **Staff Qualifications**: While we agree that staff delivering the services must have a firm knowledge about the expectations of the job in order to yield the best possible outcome, we do recognize that we have very skilled, reliable staff who have proven to provide supportive services that may not meet the qualification of an AA degree.
	+ **Suggestion:** We ask that current staff without the required college degrees be grandfathered in as qualified providers. We do support the need for the specialized certifications, however we do believe that if this is a requirement, the fees associated with certifying staff should be paid by DODD**.**
* **Reimbursement Rate:** We don’t see the need to have a different rate for Integrated Community Supports and Integrated Prevocational Supports. The staff qualifications are the same.
	+ **Suggestion:** Make the rate of Integrated Community Supports the same as the proposed rate for Integrated Prevocational Supports.