

THE PROVIDER PERSPECTIVE

Presented by

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Why is this important?

- Without the providers, public and private, community supports would not exist
- DBHDS is emphasizing “right sizing” plans of care and focusing on natural supports – decreasing reliance on “staff-heavy” models and increasing reliance on families to provide supports in their homes longer
- However, there will continue to be individuals whose needs will exceed what elderly parents can provide, who might choose to live more independently and/or will need assistance to have meaningful activities during the day

In this presentation

- We want to talk about the challenges of getting from here to there; in order to develop a business plan to meet the expectations of the new reality, providers will need information
- The graphic on the next slide will point out some of what is needed – getting from here to there!

Final approval of the “rates study” which will define not only the rates but also the units of service, define revenue potential and offer incentives by service type and size

Final List of Services to be included in each Waiver with provider requirements including staff qualifications, licensing regulations, service limitations, etc

Completion of SIS assessments on each individual to give the provider an estimate of potential revenue

Clear direction and timeframe for transition to the expectations of the CMS “Final Rule” on the definition of community

Final Approval of the Rates Study

- Existing services will change with different units of service (daily vs hourly; hourly vs 1-2.99 hrs; for example)
 - This allows more or less flexibility
 - Potentially different staffing patterns
 - Revision of documentation protocols (to accommodate the new unit definition)
- The plan for Congregate Residential (group homes) is to incentivize smaller group homes by paying a higher rate; this may cause providers to want to adjust group home size with resulting financial impact of sale/purchase of property, etc.
- This will require approval of CMS and the General Assembly in the 2016 Session.

Final List of Services

- Providers can only plan and implement strategies to provide the new services when they know
 - What they are
 - What the limitations are in providing the services
 - What the staff qualifications will be
 - What the specific licensing regulations will be, and
 - What the rate of reimbursement will be
- Some of this will be available when the new waivers are approved by CMS
- The rest is dependent on the regulatory process of DMAS & DBHDS, and/or
- Action of the General Assembly in the 2016 Session

Completion of SIS Assessments

- The SIS Assessments will determine the levels/tiers
- The tiers will determine the reimbursement rates which will set revenue for the providers
- We can not get a commitment from DBHDS when they will be completed
- As the level/tier will determine revenue for some specific services – having this information is critical for planning

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- We have been told that based on the sample done last year there are 222 individuals assessed as Tier 1 currently living in group homes – it seems to be the general assumption that these are the individuals who will move to the “independent living” supports for which slots are requested
- We have asked the ages and length of stay in their current home as that will greatly influence whether or not these individuals might or might not wish to move to an apartment
- DBHDS knows the names and the current providers for these individuals – it is their expectation that Tier 1 individuals will not generate enough revenue for a provider to be able to support them in a group home, and
- It is worth noting that for some smaller residential settings, a Tier 1 individual may produce higher reimbursement under the proposed rates plan than current rates

Implementation of the CMS “Final Rule”

- This “Rule” which will be finally implemented in 2019 has some significant impact on how both residential and day services are provided
- There will be significant impact on larger group day services, sheltered workshops, residential programs which are considered “isolating” by federal definition
- While the transition is a five year process, there will potentially be disruption in the lives of many, provider cost in converting or abandoning services, and loss of jobs

Where is here?

- Providers are financially stressed
- Providers are spending proportionally more time and staff resources to respond to the demands of the protocols for discharge, the Quality Assurance efforts, the extra visits by the Case Managers, and constantly changing procedures, protocols and expectations!
- Staff wages are low with resulting high turnover and staff who work multiple jobs just to get by
- Businesses do not thrive on uncertainty!

Where is there?

Recommendations Phase 1:

- Expedite the completion of the SIS's and finalize the rates study to give providers a basis for planning (January 2016)
- Preserve and implement the “rates” study – it has many good elements, incentivizes the types and sizes of services that meet new rules (FY17)
- Do necessary service modifications to support the “rates” study (FY17)
- Convert the three waivers as planned with no reduction in service options (FY16/17)

Where is there?

- Recommendations Phase 2:
 - Build on the experience with:
 - establishing levels of support needs,
 - forming person centered plans which look at the array of service options needed for that specific individual, and
 - using the greater flexibility inherent in the new service options
 - Manage cost by using the above to develop service “packages”
 - Be conscientious about preserving the best elements of our system including choice, flexibility to provide life long care and support, and the principle of a “home” in the community for everyone.