



December 14, 2009

To: Commission to Enhance Agency Outcomes Public Hearing

From: Alyssa Goduti, Vice President for Public Policy

Re: Comments on "Proposed Areas of Focus"

We are pleased to comment on a number of the "Proposed Areas of Focus" developed in draft by the Commission to Enhance Agency Outcomes.

The Connecticut Community Providers Association (CCPA) represents organizations that provide services and supports for adults and children with disabilities and other significant challenges including children and adults with mental illness, substance use disorders, developmental and physical disabilities. Community providers serve more than 500,000 of the state's most vulnerable residents.

We are pleased that so many of the areas under consideration relate to the provision of human services. While some of these reforms may be possible to enact relatively quickly, most recommendations in the human services area will necessitate a staged development period so that services and supports are not destabilized.

Focus Area #1. Review delivery of state human services focusing on being more consumer driven, efficient, accountable and transparent.

Services that might be consolidated among the human services state agencies include:

- Data reporting systems

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- Documentation of client demographics
- Documentation of outcome measures
- Common RFP process
- Contracting documents, policies, procedures, budget and personnel documents
- Licensing protocols
- Electronic Health Records
- Audit compliance protocols

Data systems

Currently human services providers are required to file different data reports to each state agency with which they contract. This means that DDS, DMHAS, DCF, SDE, DPH, DSS, CSSD and DOC contractors must utilize different systems in filing reports with the state.

Many community provider organizations contract with both DCF and DMHAS and many provide services under the Behavioral Health Partnership (BHP). This year alone, both DMHAS and DCF revamped their data systems requiring an overhaul of data reporting elements that necessitated modifications in programming, software and hardware and required extensive staff training. Both systems are different. Neither system relates to the other system and neither system communicates with the data system. The state made a considerable financial investment in each system, and the community providers made their own investments in hardware, software programming, consulting and training, little of which was reimbursed by state contracts.

Legislative initiatives may result in further changes in the reporting requirements as legislation requiring outcomes for DCF contracts is implemented and as the Program Review Committee completes its recommendations on Results Based Accountability.

DDS is in the process of shifting to a new data reporting system as the agency converts more services to the HCBS waiver. Many DDS contractors are also DMHAS and DCF vendors.

Common RFP process

In FY09, the OPM Purchase of Service Unit led a project to develop a common RFP process. State agency contract managers and service providers participated in the development. At present, each state agency administers its own version of RFP, RFI or RFQ on the DAS website. For those providers seeking to contract with more than one state agency, completing these RFPs takes far more time than necessary. If there were common formats and requirements, it would be quicker and less costly to respond to RFPs and the state agencies could be more efficient in their candidate selection. This project appears to be moving slowly with the round of early retirements and staff changes at OPM.

Contracting documents, policies, procedures, budget and personnel documents

Each state agency utilizes its own contract application documents. Each state agency utilizes its own format for reporting on the budget for the service and each state agency has different requirements for reporting about the personnel working on the contract.

Contracting policies differ among the state agencies in such areas as shifting funds between line items, progress report formats and timelines, budget report formats and timelines.

Common formats, policies and procedures would result in more efficient service provision, with less time spent on administrative functions and more time allocated to direct services.

Licensing protocols

DDS, DCF, DPH and DMHAS have different licensing requirements for many varied services. It would make fiscal sense to establish one overarching licensing protocol that would relate to all services that are licensed by the state, with sections that relate to the specific programs funded by individual state agencies.

There is some movement in this direction as required in legislation related to the Program Review Committee study of substance abuse treatment for adults, which requires the integration of DMHAS and DSS licensing for substance abuse services.

Creating unified licensing would be a huge task because each state agency has contributed years of work in developing the licensing standards within its purview. Equally, the provider community has invested an extensive amount of time in working with the state agencies to develop the licensing standards and the interpretive guidelines and works every day to implement the licensing requirements. It would be very costly to overhaul and unify licensing, but in the long term, there would be greater system efficiency.

An alternative to licensing would be for the state to grant “deemed status” to agencies and programs accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or CARF the Rehabilitation Accreditation Commission. Deemed status would eliminate the need for or reduce the need for the extensive system of licensing inspection currently in practice.

Electronic Health Records

Private provider agencies are at work developing EHR systems that protect client data but allow for the sharing of data for billing, quality assurance, audit compliance and other purposes.

There is no state support for the development of these expensive systems and each provider agency is working on the development on its own.

Our association provides training and networking opportunities around EHR and we are in discussions with DPH and hope to enter into discussions with DSS around resources, such as ARRA funds, that can support behavioral health and developmental disabilities providers in developing these systems. There are ARRA incentives for physician practices to develop EHR. It makes no sense for 350 private provider organizations to develop their own EHR systems, rather than the state providing an incentive for the development of such systems which, while costing money now, will save money in the long run.

Audit compliance protocols

DSS has responsibility for assuring contractor compliance with the Medicaid program. DSS audits have been in effect for many years, but in recent years the federal government and the state are expanding their efforts to detect “Medicaid fraud.” DSS has an expanded number of auditor positions and the FY10 and FY11 budgets include large financial recoupments from Medicaid providers.

Adult behavioral health providers have experienced Medicaid audits for many years. Most children’s behavioral health providers were audited in FY09 for the first time in many years. The result has been a significant number of audit findings, largely due to errors in documentation that could result in large paybacks to the State of Connecticut.

While these organizations are working with their own attorneys to address their individual agency situations, this latest round of audits has revealed serious flaws in the state’s audit process. There is no one audit guideline document notebook, no publically available audit guide, no compilation of state and federal law, regulation and policy that governs the audit process. DSS has been less than forthcoming about policies and procedures and has not been responsive to requests to meet with the industry about audit issues or to provide training for the contractors.

The next wave of audits will affect providers under contract with DDS. Once again, the request for training and written protocols has not been forthcoming.

The State may recoup millions of dollars from these private contractors, but it will be at the expense of service provision.

It makes far more sense for the legislature to require openness and transparency in the Medicaid audit process so that service providers can have all the training and technical assistance tools in hand to meet the requirements in a cost-effective, efficient way, rather than being out of compliance and returning money to the state at the expense of the programs and the people they serve.

Fiscal Reporting System – A Positive Prototype

There is a positive prototype that provides a model for developing common data reporting systems.

The Purchase of Service unit at OPM, in conjunction with community providers, developed a common cost reporting system, the Uniform Cost Accounting Standards. Human service providers are required to submit financial data in a consistent format to the human services state agencies.

There are written protocols and updated guidelines, posted on the OPM website that can be utilized by contracting state agencies, community providers and contracted auditors and accountants alike.

We would encourage your committee to support use of a similar model in order for the state to develop common data, contracting, licensing, audit, and EHR systems among the human services contractors.

The OPM Purchase of Service Unit has minimal staff support at present. While state agency representatives have met to discuss development of common contract documents, this has not been implemented. The state could achieve efficiency in its contracting process if the OPM POS Unit or another unit in state government were required to develop these protocols in conjunction with community provider representatives.

Focus Area #6. Streamlining licensing and permitting processes

Per our comments above, we support mechanisms for streamlining the licensing processes for human service providers.

Focus Area #10. Cooperative Purchasing Agreements.

We support efforts to create larger buying pools, whether for health insurance or products or other services that will include tax exempt organizations such as community providers. Some of our members are taking advantage of the ability to purchase items off the Connecticut purchase

list. Our organizations have limited buying power and group purchasing makes sense. Developing such groups across state boundaries could assist human service providers in living within their budgets in times of rising costs and cuts in state funding and reductions in charitable funding.

Focus Area #16. Consolidating the “Steering Function” across existing state agency lines

As you consider this option, please include community providers in developing the framework. While consolidating functions across state agencies may make sense – for example – purchasing “Employment Opportunities” for individuals with disabilities through one contract rather than from DSS, DMHAS and DDS, there may be funding restrictions (such as federal Vocation Rehabilitation or CMS Home and Community Based Waiver or the Mental Health Block Grant) and there maybe practice standards that speak to providing services for individuals with different disabilities in different programs.

There is a recovery-oriented prototype in its early stages among DCF, CSSD and DMHAS that allows for common contracting, monitoring and service standards.

Any proposal that seeking to re-procure and/or consolidate the constellation of human services, as this concept seems to imply, will have the effect of destabilizing a service delivery system that has deep roots in communities across the state.

Focus Area #17. Providing Community Services

We support providing community-based services for individuals with mental illness or addictions who would do far better being served in their local communities that being incarcerated. While community services cost less than institutional services, an expansion of these services should cover the “cost of services,” not just cost less than prison services. We want these programs to be successful and sufficient, stable staffing for these programs, and any community-based service, is essential.

If these services are reimbursed under Medicaid the cost of providing these services in the community will increase in order to meet Medicaid standards, billing and institute corporate compliance measures. These services will be subject to the same audit process described above.

STS Conversion

As you consider the savings in moving individuals from the Correction system to community-based systems, consider other institutional settings run by DMHAS, DDS or DCF that could be provided in the private sector more cost-effectively. You could start by analyzing the cost to run Southbury Training School, one of the few remaining institutions of its kind in the country, with providing those same services through contracts with community providers.

Focus Area #25. Pursuing a Section 1115 Medicaid waiver for the SAGA program

As this waiver is developed we ask that you assure that services for individuals with mental illness and addictions are “carved out,” much in the format of the Behavioral Health Partnership (BHP) that serves children and their moms with mental illness and/or addictions or the General Assistance Managed Care Program (GABHP) for State Administered General Assistance (SAGA) program administered by DMHAS.

It will be important that the increased rates that mirror the Medicaid rates cover the “cost of services” for a hard to serve population. Utilizing Medicaid as the funding source will require service providers to restructure their services in order to meet Medicaid standards, billing and institute corporate compliance measures. These services will be subject to the same audit process described above.

There are services currently funded through SAGA that aren’t reimbursable under Medicaid such as certain residential or other support models. These services need continued funding in order for those served to be able to have access to the full array of community-based services.

Discussion of the SAGA program is timely given that the Governor's deficit mitigation plan proposes to freeze SAGA intake. If the SAGA program is frozen the DMHAS General Assistance Behavioral Health Program (the DMHAS SAGA Carveout) will shut down within the year. With no new admissions and individuals leaving the program at the end of their limited lengths of stay there will be no substance abuse detox or treatment services available for the GA population. DMHAS data show that 32,793 individuals were served in the SAGA program in FY08, meaning that 32,793 individuals could lose service in the SAGA program alone.

Focus Area #26. Seeking new federal revenue for existing DMHAS services

We support utilizing the Medicaid Rehab Option to the full extent possible. Connecticut is the only state in the country to not make full use of the Rehab Option.

We had worked closely with DMHAS several years ago in developing a MRO model for the ACT program, but the State didn't pursue this federal funding. ‘

If the State were to pursue MRO funding it would be important to develop the programs and services in a collaborative way between DMHAS and the community providers to assure that the “cost of services” is covered, to assure that staffing patterns are “do-able” and the be sure that consumers can “tolerate” the enhanced and expanded programming. For those consumers too ill to be served through the MRO, there need to be alternate funding streams available.

As with the implementation of other Medicaid eligible services, utilizing Medicaid as the funding source will require service providers to restructure their services in order to meet Medicaid standards, billing and institute corporate compliance measures. These services will be subject to the same audit process described above.

Focus Area #27. Maximizing federal revenue by billing Medicaid for outpatient services by DMHAS state operated and contracted providers

We support efforts to maximize Medicaid reimbursement as long as the “costs of services” are met and as long as individuals not eligible for Medicaid have continued access to services

Focus Area #28. Facilitation of a statewide, interoperable EHR system to reduce health care costs and improve the quality of services.

We support the development of a statewide EHR system and want to assure that behavioral health and developmental disabilities service providers are included in the constellation of eligible parties. Repeating our comments in #1 above:

Private provider agencies are at work developing EHR systems that protect client data but allow for the sharing of data for billing, quality assurance, audit compliance and other purposes.

There is no state support for the development of these expensive systems and each provider agency is working on the development on its own.

Our association provides training and networking opportunities around EHR and we are in discussions with DPH and hope to enter into discussions with DSS around resources, such as ARRA funds, that can support behavioral health and developmental disabilities providers in developing these systems. There are ARRA incentives for physician practices to develop EHR. It makes no sense for 350 private provider organizations to develop their own EHR systems, rather than the state providing an incentive for the development of such systems which, while costing money now, will save money in the long run.