

**Comments on DPW/ODP Draft PPS Policies  
And Cost Reporting Instructions  
April, 2008**

The comments contained herein are in response to letters from Deputy Secretary Kevin Casey dated March 27 (Including Attachments I, II and III), March 31 and April 3 as well as Cost Report Instructions for the Mental Retardation Program and accompanying spreadsheets dated March 28, 2008. We are dividing our comments into two parts, responding first to the policies that are put forward in these documents and then to the specifics of the cost reporting instructions and spreadsheets. In preparing these comments, we have engaged in discussions with Philadelphia County MRS, and with a large group of Philadelphia service providers, (both our members of the Philadelphia Coalition and members of the Philadelphia Alliance) along with their fiscal officers.

**Comments on Policies Surrounding Rate Setting and Cost Reporting**

- 1. COLA and Margin** - Attachment I describes a process for determining actual audited expenditures from a prior period which will be trended forward. In Attachment II, in the discussion of Margin, it states that "the actual percentage of margin included in the rates will be subject to DPW's budgeting process." A very significant issue for providers is solvency during this transition process and beyond. There are many aspects of this process which are likely to hurt providers financially (and thus, individuals and families seeking service) and it is absolutely critical that the ability to trend rates forward and permit providers to retain revenue not be dependent on the whims of the budgeting process. We are not at all clear about how rates will be trended forward, nor how margin will be assured. We are particularly concerned that cost information based on 2008 cost reports will be two years old when rates go into effect for 2010. Two years worth of inflation will need to be trended forward to 2010. **We strongly recommend that annual cost of living increases be built into this process, for the long term, much as they are for ICF/MR facilities, through support of legislation and/or regulation that would mandate the use of the Home Health Market Basket Index for trending rates forward each year. The percentage of margin permissible in the rate setting/cost reporting process must also be agreed upon and established for the long term, through regulation or legislation and not be negotiated annually through a political process.**
- 2. Time Lines** - ODP is requesting that providers complete cost reports based on FY 2008 data in August and September of 2008. Going forward, cost reports are expected to be completed by November 15 of the following fiscal year. For this year, with the need to crosswalk expenditures to new service definitions, the fact that providers will be billing in PROMISe for the first time and are likely to have outstanding/unresolved (pending) claims into FY 2009, the fact that providers are not currently tracking information in the

format necessary to provide the data required and the fact that they will not have completed audits, it seems highly infeasible that the majority of providers could meet this deadline. A rushed process will lead to inaccurate or inadequate data to support the critical rate setting process. Currently, provider audits are due on October 31 and our county leadership tells us that many providers do not meet this deadline. Thus, going forward, November 15 does not seem like a realistic deadline for cost reporting. **We recommend that the deadline for cost reporting be no earlier than January 30 of the following fiscal year.**

- 3. 4300 Regulations** - There is a significant amount of confusion regarding the federal fiscal requirements that are based on OMB Circulars A-87 and A-122, versus the existing PA 55.4300 regulations. It appears that in some cases the cost reporting requirements follow the 4300s and in other cases follow the federal regulations; it thus appears that federal government permits some discretion for the states. Of particular concern is the allocation methodology among Direct, Indirect and Administrative costs. It seems that a number of costs that were considered direct costs under the 4300 regulations are now being considered as indirect or administrative (e.g. training, transportation, supervisory positions). It is unclear to providers how much flexibility they have to allocate their costs among these categories and there is a concern that pushing many of the costs out of direct will create costs in indirect and administrative that pass the acceptable limits. **We request that ODP clearly indicate where the 4300 regulations are being superseded by federal regulations and recommend that ODP provide a crosswalk between the pertinent federal regulations and the 4300 regulations. Where there is flexibility afforded to the state, we recommend that ODP continue to use the known and accepted 4300 Regulations.**
- 4. Policies Still Under Consideration** - With regard to policies still under consideration, (Attachment II, p. 4) including vacancy management and depreciation of buildings, we regard these as critical issues to resolve. Vacancy management, in both residential and day programs, is something that is largely out of the control of providers, particularly since providers are not permitted to market or advertise their services. If there are not individuals with resources allocated to them in the pipeline for a particular vacancy, it can be vacant for a prolonged period of time. The Coalition, as well as other provider organizations and the FIAT have made a variety of recommendations which seem not to have been accepted by the Mercer Consultants or CMS. It seems that it is incumbent upon the state to determine a mechanism, possibly through a reserve fund, to address this issue. With regard to depreciation of property, providers have pointed out that there are disincentives to own property built into this plan. The current 8% participation allowance helps to keep assets in the MR system. Ownership provides stability to individuals in service, helping to avoid eviction from their homes at the whim of a landlord. It also supports a sense of community because individuals do not have to move frequently and can become part of their neighborhoods, thus supporting relationship building and a comfort level of neighbors who may be wary of renters. It is more difficult to assure that rental properties are maintained adequately by landlords and when they are not, to manage the impact on the individual's quality of life. In addition, owning property provides collateral which allow agencies to obtain credit from their banks; without cash (and most providers have less than 90 days cash available), a dependable margin or real estate, it is unlikely that banks will continue to lend to providers. **This, along with the**

**above noted issues related to margin and trending of rates, is critical to maintain a healthy provider network.**

- 5. Advances** - This leads to the issue of advances, which are addressed in the April 3 letter from Deputy Secretary Casey. It is a good and appropriate decision to permit advances in the first quarter of FY '09 and to work with counties and providers to assure that providers are able to bill effectively through PROMISE. We are not sure, however, in a county as large as Philadelphia, whether it is feasible for the county to work with every provider individually and to pay on a regular basis through the remainder of the FY, as if the provider is being paid by PROMISE. Our county leadership has indicated that it would be difficult to reimburse providers more frequently than monthly – they would not be able to send providers a payment for every PROMISE remittance. **We recommend that the administrative entities be permitted to continue providing quarterly advances throughout FY 2009 to those providers who are successfully billing all of their services through PROMISE. They can then work, individually, with providers who need more assistance with the billing process. Given what we anticipate will be the many challenges with this overall transition, we also recommend that ODP request from CMS permission to provide cost settlement at the end of FY 2010 and preferably through the end of 2011. In addition, we strongly recommend that ODP develop a contingency plan for assisting providers that are negatively impacted during the transition process, because of insufficient referrals, difficulties in shifting their business processes, or other factors that cannot be anticipated – up to and including responding when a provider goes out of business and individuals in service have to be placed on an emergency basis.**
- 6. Fee Schedule Services** - It is noted in Attachment I that certain services are not subject to cost reporting, but rather will be subject to a fee schedule. How will these fees be set? The list does not seem to include those services that have traditionally been considered “add-ons” to residential services, such as 1:1 staffing. As individuals in the system age and develop medical problems or retire (thus being home during the day), their staffing needs change. We provided comment on the service definitions, earlier this year, that a differentiation based on the number of people living in a site would not always be sufficient to cover the costs of that site if there were individuals with very intensive needs. It appeared, from those definitions, that additional staffing, when needed, would be purchased via a fee schedule. While we do not necessarily agree with this approach, there does not appear to be anything in these cost reporting documents that takes into account the need for this type of additional staffing. This could be short term, because someone has been in the hospital and needs additional support upon returning to his/her residence – or it could be long term because the individual has complex needs that cannot be met with a basic staffing level. **We recommend that the cost reporting policies and instructions address these circumstances.**

#### **Comments on Cost Reporting Instructions and Spreadsheets**

1. We are appreciative of the fact that ODP will accept further input from providers during the training sessions that will be held, as it is difficult to identify all of the concerns that fiscal officers may have in completing these reports. However, to not provide more time for a process that represents a radical change in the way services are delivered and paid

for is incomprehensible. ODP was going down a very different road for a long time and this marks a radical departure from what was expected by everyone in the system. To try to understand and make changes in service definitions and changes in cost reporting all at one time, while providers gear up for a new billing process through HCSIS seems like a recipe for failure. **We believe that new service definitions should be put in place, providers should all be billing fully in HCSIS/PROMISE, and that the cost reporting mechanism be streamlined to a realistic level before rates are set using this methodology.**

2. As noted in our comments on the policies, the information that is being requested here is generally not collected in this way by agencies, currently, and our fiscal officers believe that it will be very difficult and extremely time consuming to accurately break out information in a format that is this detailed. For example, in a day program there are 3 “W” codes, each based on a different staffing ratio. According to the instructions, providers will need to split out staff within the day program for direct, indirect and administrative wages by job roles based on the units provided for each “W” code in the program. Since these “W” codes are ratios, the units will need to be proportionately factored to a ratio to split out the costs (e.g. 1:3 units would be 1/3 as opposed to 1:1 units.) Offsetting revenues will need to be broken down as well, in the same way. Staffing for base funded individuals in the same program would also have to be broken out in the same way. This is only one example of the complexity this approach creates. Providers note that this approach seems akin to cost reporting for hospitals; some also have had experience, a number of years ago, when such a system was proposed for Medicare Partial Hospital programs. The result was described as a “disaster.” Most agencies do not currently employ cost accountants, but all are clear that they will need to expend considerable resources for additional MIS and accounting staff to complete these reports – costs that should be going to provide services to individuals and families. Has ODP obtained any consultation from accounting firms to determine what the cost of this process might be? Will the costs to agencies for MIS and accounting services be allowable? **While a prospective cost reporting approach is acceptable to our providers, in principle, we strongly recommend that efforts be made to simplify the ways in which costs may be tracked and reported, as the community system is not prepared or funded for this type of overly detailed reporting.**
3. Schedule A, p. 11. In Column A, the provider is to enter all provider expenses. The reason given is “so the method and result of the allocation or apportionment of costs to all services and programs of the provider site(s) is documented.....” All of our providers are multi-service providers who provide mental health, substance abuse and home health services, among others – some across multiple counties. As MR expenses would not be allocated across these other services, we do not understand why it is necessary to report on these other lines of business. **We recommend that only MR expenditures be included in these cost reports.**
4. Schedule A, p. 12. The item, “residential occupancy costs not attributed to habilitation services”, is listed for both column D and column F. Please clarify what is the difference between the two.
5. Schedule A, p. 12 and p.23 (Line 14). We do not understand why ODP has chosen to use a Modified Compensation Review System or Personnel Action Plan so set salaries when the provider will be fully at risk. This is particularly problematic for some of the specialty positions that are required in MIS and Accounting departments, as it is difficult to recruit qualified individuals at the salary levels that are set. **We recommend that**

**ODP recognize that the providers are bearing significant risk and allow the market to determine compensation.**

6. Schedule A, p. 18 (Line 3) For transportation, only depreciation is mentioned. It is unclear how agencies are to capture the costs of gasoline and maintenance for vans used by residential sites, especially when these sites are shared by both waiver funded and base funded individuals. Also, there is not a 1:1 correspondence of vans to sites; vans are shared between and among sites with multiple sites using them to provide consumer services. In Line 11, monitoring visits by supervisors are considered indirect costs, where traditionally salaries/benefits of first level supervisors have been considered a direct expense. Would this also be true of job coaches who travel to meet individual consumers at places of employment?
7. Schedule A, p. 19 Providers are used to including utilities, phone and rent as direct costs related to the individuals at specific sites. Are we correct in understanding that all of these types of expenses are now considered administrative?
8. Schedule A, p. 28 (Line 24) states “enter the total number of allowable units of service provided and billable”.....should this be “billed?” How should providers account for services that were provided in an emergency situation, by request of the county or ODP that could not be submitted for reimbursement because they were not authorized through HCSIS? How would costs related to vacancies be captured?
9. Schedule B, p. 31. The Income Statement does not appear to include a category for room and board revenue that is paid to the provider by the consumers in residential programs. We believe that ODP and Mercer may be operating under a misapprehension that rents from individuals cover all room and board costs. This is clearly not the case. (For example, utility costs increase at a far greater rate than the SSI that clients receive.) How should providers show costs that are above what is covered by rents, when room and board is not an allowable cost? It seems that both room and board costs and revenues must be shown in the report.
10. Schedule E, p. 41. ODP is considering the development of a grandfathering policy for existing buildings and providers. Please clarify what is meant by this. **With regard to depreciation and use allowances, we recommend that the 4300 regulations be used to fill in the blanks in this document.**
11. A general comment from some of the people who tried to navigate the spreadsheets in Excel is that they do not seem very user friendly. This may be because they are draft documents; however, it is critical that where the schedules relate to one another, there must be ease of populating one schedule with information from another schedule.

**Two final comments:**

1. It was suggested to us that we should focus only on 3 or 4 key issues that we wanted to bring to the attention of ODP in response to these policies and procedures. Instead, we have created a 6 page document because we have found the issues and questions to be so far reaching and concerning. The bottom line is that we believe that **the MR system, including ODP, counties and providers are not ready for a fully functioning fee for service system to be in place by July of 2009 – less than 15 months away – because**

- **Adequate infrastructure/systems are not in place at any level**
- **There will be significant cash flow issues**
- **There are significant policy decisions that have not been made and questions that have not been answered.**

2. As we have been since this process began, the Philadelphia Coalition is concerned that this approach to setting rates will severely limit consumer and family choice. As providers (particularly large ones) will necessarily have to average rates among sites, it will be more difficult to accept individuals with higher levels of need because it is not cost effective. If there are not enough referrals to keep a site open or if long-term vacancies occur, homes and programs will close and individuals will have to go where there is capacity, not necessarily where they will be most satisfied or will have their needs best met. While our providers want to cooperate with the efforts of DPW/ODP to maintain the Home and Community waivers, they are becoming increasingly anxious and pessimistic that these changes will not severely damage the MR system and the individuals and families it serves. We sincerely hope that we will be proved wrong.

The members of the Philadelphia Coalition are very appreciative of the opportunity to provide comment on these very important policies and procedures. We anticipate that our providers will continue to provide feedback as this process moves forward.