CCH Rate Structure Committee Meeting
September 12, 2012

In Attendance: Mary-beth Santarsiero, Jeannine Pettinico, Mary Beth O'Neill, Peter Mason, and Kathy Calo.

Absent: Carol Grabbe, Tim Lavoy, Catherina Ohm, and Sheryl Kemp

Topics for Today:

1. Definitions relating to 24 hour supports and supervision levels
2. Catherina will obtain DOL information
3. Examine components of CTV rates
4. Defining expectations for level 7 homes

CCH Coordinators will clarify the definitions relating to 24 hour supports as well as supervision levels as they relate to the rates. The coordinators will look at the LON to make sure everything that is required in a CCH is addressed in the LON. The group will then block off questions to come up with a composite rate to get to CCH Rates 1, 2, and 3. The Day and Res composite scores will be reviewed, it may be that a CCH composite score is required. The CCH checklist will then be matched up to the LON. The questions pertinent to CCHs would make up the determination for the composite score.

Peter pointed out that a person who is a LON 4 may not need 24 hour supervision. This example would then not actually equate to the person's Level of Need if a person who is a 1 or 2 became a rate 1 (no overnight supervision), or a 2,3,4,5 would be rate 2 (24 hour supervision required)and 6, 7 would be rate 3. CCH coordinators will review and bring feedback to the committee. Tim did go through the LON thoroughly to examine the components. Peter reminded the group, "Do not create a system for the outliers!"

The LON does not take the place of every other assessment. The LON should truly reflect each person's current need. Some people need a home alone assessment. Other assessments should support the LONs. The LON not only target's behavioral issues in the last year, but any behavior monitored in the last year, etc. If the environment is set up to monitor behavior, then that is continuous supports and should be addressed. The LON manual should be a focus for every agency, case manager and then disseminated to the team.

The group will examine components of CTV rates and the number of clinical hours of supports. Each person can get up to 6 hours of behavior and nursing. Clinical and nursing hours are combined and flexed among the individuals. One region is working with an agency that has no nursing, so the cost of nursing is divided and the region is paying for nursing based on each individual, but on an average of everyone receiving service. Some will get more and some will get less. In one region, if you go over your hours, the agency will go to PRAT and justify the need for additional hours. The questions was

asked as to how the hours are tracked so it can be determined what the other individuals are using for services. Cost settlement has always been the case in the CCH contracts.

Currently, nurses in one region are conducting a time study as there are reports that the requirements are not feasible. A study to assess behavior hours will occur at a later date.

CTV rate – In committee meetings and notes, providers are the private providers like Key, HART, etc. The committee will be examining components of CTV rates including clinical (nursing, and behavior, etc.) Monthly, face to face visits and monitoring forms are the expectations of the private provider. A comprehensive report is completed that includes individual entitlements, personal funds, and recreational expenses.

Committee members inquired about how we should let private providers know that clinical supports are cost-settled in the master contract. All agencies should hear a consistent message. One region has been informing providers about cost settlement. The new contract will say cost settlement is required. DDS will not do any one time requests for increased CCH clinical needs.

Jeanine will work with Kathy and Mary-beth to define what we are calling Shared Living versus our current CCH system. If Rate 3 equates to comprehensive, an application of Rate 3 to Levels 6 and 7 could be a significant jump up in payment. Shared Living would be higher levels of support with increased staff, respite, and vacation time for licensee and with the downsizing of public, this would be a great use of state staff. (Live-In Companion)

A few questions will need to be answered in future meeting. Define Shared Living – would it work in the CCH program?

- Is it licensed?
- Who owns the home?
- Provider can own or rent
- How many people would live there?

CCH vs. Shared Living –
CCH must follow the regulations as outlined, but a Shared Living situation might be something outside of these parameters. The committee would like to review the benefits of fostering a natural bond versus creating a medical/regulated home. One concern would be that the people served may have intense needs and there would be a lack of oversight that comes with a regulated environment.

We need to make these recommendations in order to present them to the residential rate committee. The committee will lay out all questions. For example, a Shared Living model will be more than a CCH but less than a residential model. Should we call it a CRS or something else? Kathy will look at Shared Living in other states. Some states have relief staff and triage team. This sounds like an area the committee needs to explore.

The committee will define the model that is being discussed. At the next meeting, the following will be reviewed:

1. Jeanine, Mary-Beth, and Kathy will develop a spreadsheet to note the differences among the models.
2. Kathy will go through the regulations.

The committee will reflect upon the two models and discuss how we think this will work. That will guide our questions and decision making process.

Mary-beth will not be at the meeting in October.