**Selective Contracting Concept Paper Comments**

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|  | **Quality** |
|  | It is unclear as to why a selective contracting arrangement is needed to ensure quality. ODP has put many measures in place to ensure that individuals and their families receive quality services with ample focus on health and safety. It is unclear as to why ODP cannot just end the contracts of poorly performing providers without doing a complete system overhaul. Or conversely, why high performing providers can’t be placed on a less intensive licensing and/or monitoring schedule. It is our belief that if ODPs intention is to strengthen the quality of supports, the bulk of investments of time and dollars should be made into the **Direct Support Professional workforce** because quality happens at the point of direct interaction with the individual. This **coupled with i**nvestments in technology that promote independence (but does not eliminate interaction with human supports) would go a long way to strengthening the quality of supports individuals and families receive.  **Strategies to Support Workforce**  There is little evidence to support a correlation between credentialing and staff retention. Provider experience thus far is that credentialing is time-consuming, resulting in relatively few staff taking advantage of credentialing opportunities. What is needed in terms of workforce is the development of educational, skill building programs that allow for direct support professionals to be prepared to do the job on day 1. Partnerships and collaborations – by ODP – with any of the myriad colleges and universities located throughout the Commonwealth to promote development of the Direct Support Professional workforce could go a long way toward solving the workforce problem. But it must be made clear that an investment in reimbursement rates for services provided is an absolute necessity. Direct Support Professional jobs are in no way “entry-level”, and reimbursement rates must reflect that reality.  If opting for a credentialing program that includes a minimum number (percentage) of direct support staff, ODP must clearly define which credentialing program(s) are acceptable and must take steps to ensure that implementation and maintenance of credentialing programs is fully funded at the provider level, including assurances that providers can afford and have access to the technology needed to support such an initiative.  **Preferred Provider Status**  ODP should reconsider the requirement that to achieve Preferred Provider status a provider must provide all 4 services identified in the concept paper. While that certainly could be one criterion, high performing providers who specialize in supporting individuals with enhanced needs (behavioral or medical), or that consistently exceed standards regardless of needs level, in any one of the identified services should be given consideration for preferred provider status. This may help to alleviate concerns of some of the smaller, high-quality providers, who do not have the bandwidth to provide all 4 services.  **Incident Management Fidelity**  ODP should take into consideration that in many cases, problems with fidelity to expectations outlined in the most recent IM Bulletin, may be related to confusion about what does and does not need to be reported. This issue is further complicated by delayed implementation of specific parts of the bulletin during the COVID-19 pandemic.  **Employment as a Performance Standard for Residential Providers**  The concern here is why the employment-related services haven’t been made part of the selective contracting model. Given the high priority the state has placed on individuals with IDD or autism finding competitive integrated employment, it would make sense to include providers of such service in a model that incentivizes positive outcomes in this area. It does not make sense to reward residential providers for the number of individuals served who are competitively employed. Why has ODP proposed this in the Selective Contracting model?  Further, we are curious about the assertion made in the concept paper that “investment in skill development and job training may not realize savings for a number of years into the future.” Where does ODP anticipate savings will come from? Is it expected that provider costs will be less once more people are employed? That individuals will be able to cover more of their own expenses?  **Piloting**  Has ODP given consideration to rolling out the selective contracting model using a pilot program model. Given that residential and support coordination services are arguable among the more complex services offered, it may be beneficial to select a few geographic areas with a smaller number of providers to work out the kinks, particularly because this model is not being used for these services in any other state. Since it may be the first of its kind, it may be preferrable to roll out on a smaller scale first.  **Recent Compliance Trends**  Here we want to note that it appears the data used to demonstrate these negative trends has been taken from 2020 – 2022, amid a global pandemic. Struggles have been noted in nearly every area of life/service delivery during this time due to extreme staff shortages, high DSP burnout levels, increased safety needs and responsibilities, barriers to accessing medical care, and numerous other factors...is there additional data showing a more long-term trend of decreasing compliance that might suggest a need for a major systems change? |
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