FAQ's

During the recent public comment period, the Bureau for Medical Services (BMS) received many comments and questions on the Intellectual/Developmental Disabilities Waiver (I/DDW) program. Since we cannot answer each one individually, responses to the most commonly asked questions are below.

1. **Why are changes being made to this program?**

   The I/DDW program is appropriated $89 million dollars from the legislature to fund the state's portion of the waiver program which is then matched with federal funds to cover the waiver services and acute care costs for 4,634 members. In state fiscal year 2014, the total cost for the program was $385 million, including the federal funds, of which $110 million was the state's portion. This caused the program to operate at a deficit of $21 million in state dollars. Continuing to operate this program in this manner puts other state programs at risk. The State is also projecting significant budget deficits in future years as well and other state program expenditures are being reduced.

2. **How much do we need to maintain the program as is?**

   The cost to the state to maintain the program as is would be approximately $117 Million for 4,634 members. Based on the current funding of $89 Million, this would require an additional $28 Million.

3. **How much do we need to eliminate the current wait list?**

   The cost to the state to eliminate a wait list of 1,000 applicants would cost approximately $140 Million in state dollars. Based on the current funding of $89 Million, this would require an additional $51 Million.

4. **What is the anticipated process for eliminating the wait list?**

   Once we are within the budget parameters and savings are realized in this program, individuals will immediately begin to be removed from the wait list according to the "first on, first off" approved process.

5. **How often are new slots awarded and how are they awarded?**

   Since 2010, BMS has added 250 new slots to the program, but typically slots are only awarded at the beginning of a new fiscal year (July 1). Once a slot has been used for part of a fiscal year, we cannot award that slot to another person until the next fiscal year and we call these "roll-over" slots. People give up their slots for a variety of reasons, such as moving out of state or into a setting that better meets their needs. Once real costs savings are realized through the proposed changes, new slots can be added to this program. Slots are awarded in the order in which eligibility is established, in other words, the person that has been on the waist list the longest is the first to get a funded slot when it becomes available (first on, first off).

6. **I have read that the average cost per person for someone on this program is $85,000 and I have also heard it is $68,000. Which is it?**

   In Fiscal Year 2012, the average cost per person was $68,000. In Fiscal Year 2014, the average cost per person was $85,000 and the projected cost per person for Fiscal Year 2015 is $95,000.

Two things occurred on October 2, 2011 when the renewal manual for 2010-2015 went into effect that caused the average to go up significantly: more units of direct care service were made available and the rates for almost all the services were increased significantly

For example:

- Prior to October 1, 2011, a child under the age of 21 was able to receive 4-6 hours of direct care service. After October 1, 2011, this was increased to a possible 8 hours per day. For an adult over age 21 living with family, this was increased from 8 hours to 12 hours per day.

- The rate of pay to a family member for direct care service was increased from $7.80 per hour to $10.96 per hour.

Another factor that has increased the overall cost of this program is the increase in Individually Supported Settings (ISS). These are 24 hour, round-the-clock settings for adults who no longer reside with their families. With the aging population in WV, it is not surprising that these numbers have increased; however, these settings do cost more, usually in excess of $200,000 per year. At the end of 2013, there were 1,144 of these types of 1, 2, and 3-person settings. At the end of 2014, there were 1,218 ISS's. The number of 1 person ISS settings increased by 74 sites over a year at a cost of over $14 million (average cost of $190,047 per person).

7. I never use my entire budget. What happens to the unused funds?

No, neither the agency nor BMS keeps the money. The budget is only used as an estimate of potential costs for the year for planning purposes. Some people use more, some people use less. Since the program has been operating at a deficit, there is no "left-over" money.

8. Is there any flexibility in the budget?

The budgets are individualized to the needs of the person based on the assessments completed. Historical claims for everyone are factored in and an estimated budget for each person is created. This allows for flexibility in funding based on an individual's assessed need - instead of a "one size fits all" budget amount. Some people will use less and some people will use more due to unforeseen events. For example, a person would use more than estimated due to a change in a medical need, such as breaking a hip or leg and needing more assistance. Another reason might be the primary caregiver is no longer physically able to support the individual and agency staff must be used in place of family or the individual must move to another type of setting.

9. When will the new waiver rules go into effect?

The draft application was submitted to the Centers for Medicaid and Medicare Services (CMS), the federal agency that monitors and approves the waiver application, on May 8, 2015. The goal is to have the Waiver approved by July 1, 2015. Once BMS receives the approved Waiver from CMS, it will be posted on the I/DDW website. Policy will then be drafted based upon the approved application. The draft policy manual will be posted for 30-day public comment period. Once the policy manual is official, training will be provided to ensure everyone understands the new policies and guidelines.

10. **How will people be transitioned from their existing services to the rules in the new policy?**
    As soon as someone has a critical juncture, such as a 6-month IPP review or annual IPP, the new manual must be followed.

11. **What if I want to live in a 1-person setting?**
    BMS will carefully consider every request for a 1-person ISS based on a review of past history and assess needs to determine if an individual needs to have one-to-one services, 24 hours a day. All 1:1 settings will need to consider the use of Electronic Monitoring and roommate possibilities if their assessed budget is exceeded.

12. **If I currently live in a one-person ISS setting, do I have to move out immediately or get a roommate?**
    No. Prior to your annual IPP or the end of your lease, however, if your assigned individualized budget does not support 24 hours of paid support, we are asking your service coordinator to work with you to develop a plan to use less than 24 hours of 1:1 service and to possibly transition to a 2, 3, or even 4-person setting, if appropriate.

13. **If my house is owned by me or my family, do I still have to get a roommate?**
    These situations will be examined very carefully on a case-by-case basis. If your assigned individualized budget does not support 24 hours of paid support, you might not have to get a roommate but your setting may need to be able to provide some natural supports.

14. **Why did the program pay for more than 24 hours per day for people living in round-the-clock settings?**
    The reason was to allow for training of staff. The waiver will still require staff to be highly trained, but it will have to occur in the residential setting. Any group training, such as CPR or first aid, has always been an administrative cost to the IDDW providers and that will not change.

15. **I have heard that APS Healthcare is paid $66 million dollars a year to manage this program. Why do we need APS Healthcare?**
    APS Healthcare manages many programs for DHHR. The Bureau for Children and Families, the Bureau for Behavioral Health and Health Facilities, and the Bureau for Medical Services contract with APS Healthcare. The State of WV pays APS Healthcare $867,000 for managing the IDD Waiver program a year. In addition to the annual assessments, APS does authorizations for all services, reviews plans, represents BMS in Medicaid Fair Hearings, investigations, and all day-to-day operations, etc. Our federal partner, CMS, requires that every person be determined financially and medically eligible every year and that the medical eligibility assessments be done by an independent assessor (not an agency or someone who has a stake in the outcome). APS Healthcare completes the medical eligibility assessment every year.

16. **Are the changes in services only to family services? Are provider services being changed as well?**

    The proposed modifications do not only affect families. Many of the changes made will also impact providers. For example:

- Respite Services are provided by the agency and the hourly rate paid to staff is far less than $20.04 per hour, so the reduction in Respite will have an impact on the providers.
- The Therapeutic Consultant and Behavior Support Professional codes were combined and the rate for Behavior Support Professional was lowered from $59.60 per hour to $41.64 per hour. The total amount of units available was lowered as well.
- A closer examination of LPN service was instituted, requiring 15-minute schedules and progress notes to make sure that LPNs are performing duties within the scope of the LPN license when being paid as an LPN. We are encouraging agencies to use Approved Medication Assistance Personnel (AMAP) in lieu of LPNs when appropriate.
- The numbers of trips for an agency-owned mini-bus or mini-van were lowered to 2 trips a day. The total was 4 trips a day and the cost was $8.31 per trip.
- A provision was put in place to reduce the number of units available in 24-hour settings to equal exactly 24 hours. Previously, it amounted to almost 24.5 hours per day, which amounted to an additional $3,361 per person in an ISS or GH setting. With 1,335 members in 24 hour, round-the-clock settings, this could potentially save $4.5 million.

17. Were the I/DDW Provider agencies consulted about the possible changes?

Yes. The WV Behavioral Health Providers Association made recommendations to BMS on possible cost savings measures for the IDDW, including capping children at 30 hours per week and adults at 40 hours per week. BMS did not act on these recommendations. I/DDW providers were also consulted at Quarterly Provider meeting in Flatwoods on November 11, 2014 and are part of the IDDW Quality Improvement Advisory Council that meets quarterly. Additionally, every member's home and every I/DDW provider received a survey to complete regarding how the changes in the last renewal affected them and if they had any other suggestions for the program. Eighteen forums were held around the state in the summer of 2013 to discuss the survey items.

18. Where can I find information about Waiver agency profits?

The IDDW providers must report their profits to the WV Healthcare Authority. You can view these figures for 2103 by going to the following link:
http://www.hca.wv.gov/Pages/default.aspx

The figures for 2014 should be posted shortly. If you think your agency fraudulent, please report that to the Medicaid Fraud Control Unit at 304-558-1858.

19. Where can I report suspected fraud in the program?

All staff who work for IDDW agencies and in family homes must report all suspected cases of fraud to the Medicaid Fraud Control Unit who will investigate the referrals. You may report any suspected fraud to the Medicaid Fraud Control Unit at 304-558-1858.

20. **How are the provider agencies monitored to ensure that services are being provided properly?**

APS Healthcare conducts an on-site audit of every I/DDW provider every other year and the Office of Health Facility Licensure and Certification (OHFLAC) audits the providers on the off-

year. Additionally, IDDW providers are required to complete self-audits. Since 2010, BMS has recommended providers return over $3 million to the state and federal government based on services improperly provided by IDDW Providers.

21. Is it correct that Day Programs must close after two (2) years?

The reason that the Facility-Based Day Habilitation (FBDH) Programs were initially limited to two years in the draft application was the result of a CMS directive that went into effect on March 17, 2014 stating all services have to occur in integrated settings. BMS is the process of reviewing each setting to determine if it is fully integrated and, if so, BMS is willing to attest to CMS that the setting meets the requirement. If CMS agrees, then the setting will be able to continue providing services. In the meantime, based on public comment, the draft application was amended to allow Day Programs to operate for at least 3 more years and BMS has added the service of Pre-Vocational services to replace the current Facility-Based Day Habilitation service. BMS also sent a letter to CMS regarding how many people have requested that the day programs stay open, many of them elderly parents who need somewhere for their adult child to go on a daily basis. In the event that CMS does not allow FBDH to continue, then BMS urges that parents allow the Person-Centered Support Worker (whether that is a family member or an agency staff) to support the adult in the community doing many of the same things they once enjoyed at a site-based program.

22. Did the public comments have any bearing on changing the draft application posted?

Yes, while we could not respond to every comment made, every comment was read and thoroughly considered. Changes were made including increasing the proposed respite hours from an average of 2.0 per day to 2.5 hours a day, allowing respite to be provided on the same day as other direct care services, allowing both respite and Person-Centered Support services to be annual amounts that may be carried over from day to day, and increasing the proposed time limit on Facility-Based Day Habilitation from 2 years from date of the policy manual implementation to 3 years. For a comprehensive list of changes that were made as a result of public comment, please visit our website at:
http://www.dhhr.wv.gov/bms/News/Documents/Summary%20of%20IDDW%20Comments%2005052014.pdf

23. Why wasn't the legislature told about the proposed changes during the legislative session?

The Joint Committee on Government and Finance is presented with a report every month that details the spending for this program and the wait list numbers.