Intellectual/Developmental Disabilities Waiver (IDDW)

2020 Renewal Proposed Policy Changes and New Budget Methodology 2018

March 13-14, 2018 – Charleston
March 14-15, 2018 – Huntington
March 21-22, 2018 – Parkersburg
March 26-27, 2018 – Martinsburg
March 27-28, 2018 – Morgantown
April 10-11, 2018 – Wheeling
April 11-12, 2018 – Flatwoods
April 16-17, 2018 – Lewisburg




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BUREAU FOR MEDICAL SERVICES

Agenda

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- Welcome
- New Policy Requirements (as of February 1, 2018)
- Required Policy Changes (as of July 1, 2020)
- Proposed Policy Changes (as of July 1, 2020)
- New Budget Methodology
- Questions and Wrap-Up

New Policy Requirements (as of February 1, 2018)

Policy Changes: LPN Services

The policy changes to Licensed Practical Nurse (LPN) Services are effective July 1, 2018 or next anchor date.

LPN Traditional Option:

- This service can only be used for activities that require a nurse to complete according to the West Virginia Nurse Practice Act.
- Any medication administration and performance of health care maintenance tasks as described in W. Va. CSR § 64-60-1 et seq. should be provided by a trained approved medication assistive personnel.
- Including:
  - Assisting the member in the ingestion, application or inhalation of medications, including both prescriptions and non-prescriptions drugs.
  - Making a written record of administration of medications.
  - Injections of prefilled insulin and insulin pens.
  - Administering glucometer test.
  - Gastrostomy tube feedings, at discretion of RN.
  - Ostomy care, at discretion of RN.
  - Performing tracheostomy care, at discretion of RN.
  - Performing ventilator care, at discretion of RN.

Policy Changes: LPN Services (Cont.)

The policy changes to LPN Services are effective July 1, 2018 or next anchor date.

- If the LPN performs these tasks, then the LPN must drop down and bill the appropriate direct care code for Person-Centered Support code.
  - LPNs are able to bill for a med pass at a licensed Facility-Based Day Habilitation site.
- Nursing services that must be provided by an awake and alert LPN include but are not limited to:
  - Direct nursing care including medication/treatment administration unless the medications/treatments are described in W. Va. CSR § 64-60-1 et se4q.
  - Note: If these services are provided by an RN then the LPN code must be billed for reimbursement unless it is a service that may be provided by an Approved Medication Assistive Personnel (AMAP) then it must be billed at the Person-Centered Support rate.
  - This service can only be used for activities that require a nurse to complete according to the West Virginia Nurse Practice Act and may not be provided by an approved AMAP.

Provider Enrollment and Responsibilities

Direct-Care Ethics Training for Direct Support Professionals, Day Services, Person-Centered Support, LPN and Respite, must minimally address:

- Focus on the person who receives services, including commitment to person-centered supports as best practice
- Promoting the physical and emotional well-being of the person
- Integrity and responsibility
- Confidentiality
- Justice, fairness, and equity
- Respite
- Relationships
- Self-determination
- Advocacy

Freedom of Choice

- When the Freedom of Choice form is being completed during the annual functional assessment, the Service Coordinator (SC) along with other agency personnel, with the exception of the legal representative of the person being assessed or the Specialized Family Care Provider, will be excused to ensure complete impartiality.

Self-Reviews

I/DD Waiver agencies are required to submit evidence to the Utilization Management Contractor (UMC) every year to document continuing compliance with all certification requirements as specified in this manual.

- This evidence report must include a signed attestation from an appropriate official of the provider agency (e.g. Executive Director, Board Chair, etc.).
- The report may sent from a provider's Human Resources' system, an excel spreadsheet or other report that includes all applicable fields and documents the employee's training dates
- This form must be submitted electronically to the UMC and must be an electronically searchable document as it cannot be in pdf format.
- This self-review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and Centers for Medicare and Medicaid Services (CMS) Quality Assurances are met.

- The reporting periods will be based on the quarter during which the provider's on-site review takes place on a defined cycle and will be communicated to providers via email.

Transportation

Transportation Agency Staff Qualifications :

- In addition to meeting all requirements for I/DD Waiver Staff in *Sections 513.2 - 513.2.1*, the provider is required to maintain documentation at all times verifying that agency staff providing transportation services have:
  - A valid driver's license.
  - Proof of current vehicle insurance.
  - Proof of current vehicle inspection.
  - Proof of current vehicle registration.

WVIMS

All incidents must be entered into the West Virginia Incident Management System (WVIMS) within 24 hours of the occurrence of the incident or the documented time the I/DD Waiver provider is made aware of the incident.

Documentation and Record Retention

Documentation and Record Retention Requirements:

- The original physical copy of the annual assessment completed by the person, his/her guardian and/or his/her Interdisciplinary Team (IDT). Once the annual assessment is completed and the person or his/her guardian has signed the document attesting to its accuracy and completeness, it will be the duty of the Service Provider to ensure that the document is not altered, copied, or distributed in any manner. However, the Service Provider must make the original physical copy annual assessment available to the person, his/her guardian and his/her IDT at the Service Provider's offices, upon request, to review only

Facility-Based Day Habilitation

- Removed: “This service will only be available for three years following the implementation date of this manual and upon purchase of this service in the UMC portal for the individual receiving services. It is expected that after this service ends that transition to Pre-Vocational services, Job Development services, Supported Employment services, or Person- Centered Services will occur for persons receiving services.

Pre-Vocational Services

- Removed: “Services are expected to occur over a two-year period, with integrated employment at a competitive wage being the specific outcome. It is expected that after two years, transition to Supported Employment will take place.”
- Added: “Accessing and managing any personally available funds; Persons may receive minimum wage. If the I/DD Waiver provider benefits from the person’s labor, then the person must be paid.”
- The words “and community settings” were removed from this sentence: “**Site of Service:** This service may be provided in a licensed I/DD Waiver Facility-Based Day Program facility and community settings.”

Job Development and Supported Employment

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Job Development

- Removed: “Services are expected to occur over a two-year period, with attaining and maintaining integrated employment at a competitive wage being the specific outcome. It is expected that on or before two years, transition to Supported Employment will take place or Job Development Services will cease”

Supported Employment

- Site of Service: **“**This service may be provided in an integrated community work setting and may not be provided in any setting owned or leased by an the I/DD Waiver provider agency.”

Additional Changes

- There are several additional changes that have not been included in this training.
- For a comprehensive list of changes, please go to the current manual and review the change log located at the end of the manual.
- Chapter 513 I/DD Waiver Services manual can be accessed at the following link:

https://dhhr.wv.gov/bms/Pages/Manuals.aspx

Required Policy Changes (as of July 1, 2020)

Service Coordination Services

Federal independent case management requirements:

- All Home-and-Community Based Services (HCBS), are subject to requirements set forth by the Centers for Medicare and Medicaid Services (CMS), the federal entity that regulates such programs.
- This includes the I/DD Waiver program.

Service Coordination Services (Cont.)

Federal independent case management requirements:

- This means that "states are required to separate case management (Person-Centered Service Plan development) from service delivery functions."
- Having interest in, or being employed by a provider, are considered conflicts of interest.
- Additional information on these, and other HCBS requirements can be found at www.cms.gov, or by accessing the cited source.

--https://www.medicaid.gov/medicaid/hcbs/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf

Federal Conflict-Free Case Management Requirements

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- Per 42 CFR (Code of Federal Regulations) 441.301: "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS……."

--The Daily Journal of the United States Government, FEDERAL REGISTER 1/16/14--

Service Coordination (Cont.)

- Agencies that provide Service Coordination Services will provide ONLY that service and will not be licensed by the Office of Health Facility Licensure and Certification (OHFLAC), but will be certified by BMS through a certification process.
- Agencies that provide both Service Coordination and any other IDDW service will continue to be licensed by OHFLAC.
- Agencies WILL NOT be able to provide both Service Coordination and any other IDDW service to the SAME person unless there are no other willing and qualified agencies within a close geographical distance.
- Service Coordinators will facilitate all other services with other agencies licensed to serve the individual's catchment area.

Stakeholder Input

- What is your opinion on *when* this requirement should be implemented—July 1, 2020 or by anchor date?
- If you would like to provide any additional comments, please write them at the bottom or on the back of your survey.

Required Policy Change:
Electronic Visit Verification (EVV)

EVV (cont.)

- The 21st Century Cures Act requires states to implement an EVV system by January 1, 2019 for Personal Care Services (PCS) and January 1, 2023 for Home Healthcare Services or the state will be fined.
- Note: “Personal Care Services” as identified in the Cures Act refer to I/DD Waiver Direct Care Services (PCS, Respite, LPN, etc.).

EVV (cont.)

- Provider staff will use an EVV system to track and report their work time. This will be in the form of a app on a smart phone, or a land line or a QR reader. All must have GPS capability.
- EVV identifies financial accountability, increases efficiency through electronic billing (if available), reduces unauthorized services, improves quality and accuracy of services, and reduces fraud, waste and abuse.

EVV (cont.)

- West Virginia must select and implement one of five EVV models:
  - Provider Choice: providers select their EVV vendor-of-choice and self-fund its implementation.
  - Managed Care Organization (MCO) Choice: MCOs select their EVV vendor-of-choice and self-fund its implementation. Not applicable to IDDW at this time.
  - State Mandated External Vendor Model: states contract with a single EVV vendor that all providers must use.
  - State Mandated In-House Model: states create, run and manage their own EVV system.
  - Open Vendor Model: states contract with a single EVV vendor or build their own system, but allow providers and MCOs to use other vendors.

--CMS Section 12006 of the 21st Century CURES Act, August 2017

EVV (cont.)

- The state with input from the stakeholder group will determine which EVV model will be utilized, and will implement according to requirements of the 21st Century Cures Act.
- Bureau for Medical Services (BMS) continues to conduct research and interview vendors in an effort to make an informed decision regarding model selection and implementation.
- A stakeholder workgroup that includes providers, members, family and advocates, has been developed to explore options and offer feedback.
- This group will begin meeting very soon.

Required Policy Change:

Individual National Provider Identifier (NPI) Numbers

NPI Number

- An NPI number is a unique, 10-digit identifier that is issued to all healthcare providers.
- NPI numbers allow for accurate, efficient electronic submission and tracking of standard transactions.
- Currently, each I/DD Waiver provider agency has its own NPI number via which all services provided by employees of that agency are billed.
- This potentially allows for errors resulting from intentional or unintentional duplication of service.

NPI Number (cont.)

- The state has begun the assignment of NPI numbers to individual agency employees that will be associated with the provider's EVV system.
- Specialized Family Care Providers have already obtained NPI numbers and been re-enrolled in MOLINA.
- Waiver workers will have completed this by 01.01.2020.

Proposed Policy Changes (as of July 1, 2020)

BSP Services Research

- In August 2017, at the request of the BMS, KEPRO obtained and reported on data pertaining to the efficiency of the BSP I and BSP II service codes.
- The Inventory for Client and Agency Planning (ICAP) is administered for all I/DD Waiver program members each year. This assessment captures information about a person's internalized, externalized and asocial maladaptive behaviors.

BSP Services Research (Cont.)

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Methods used:

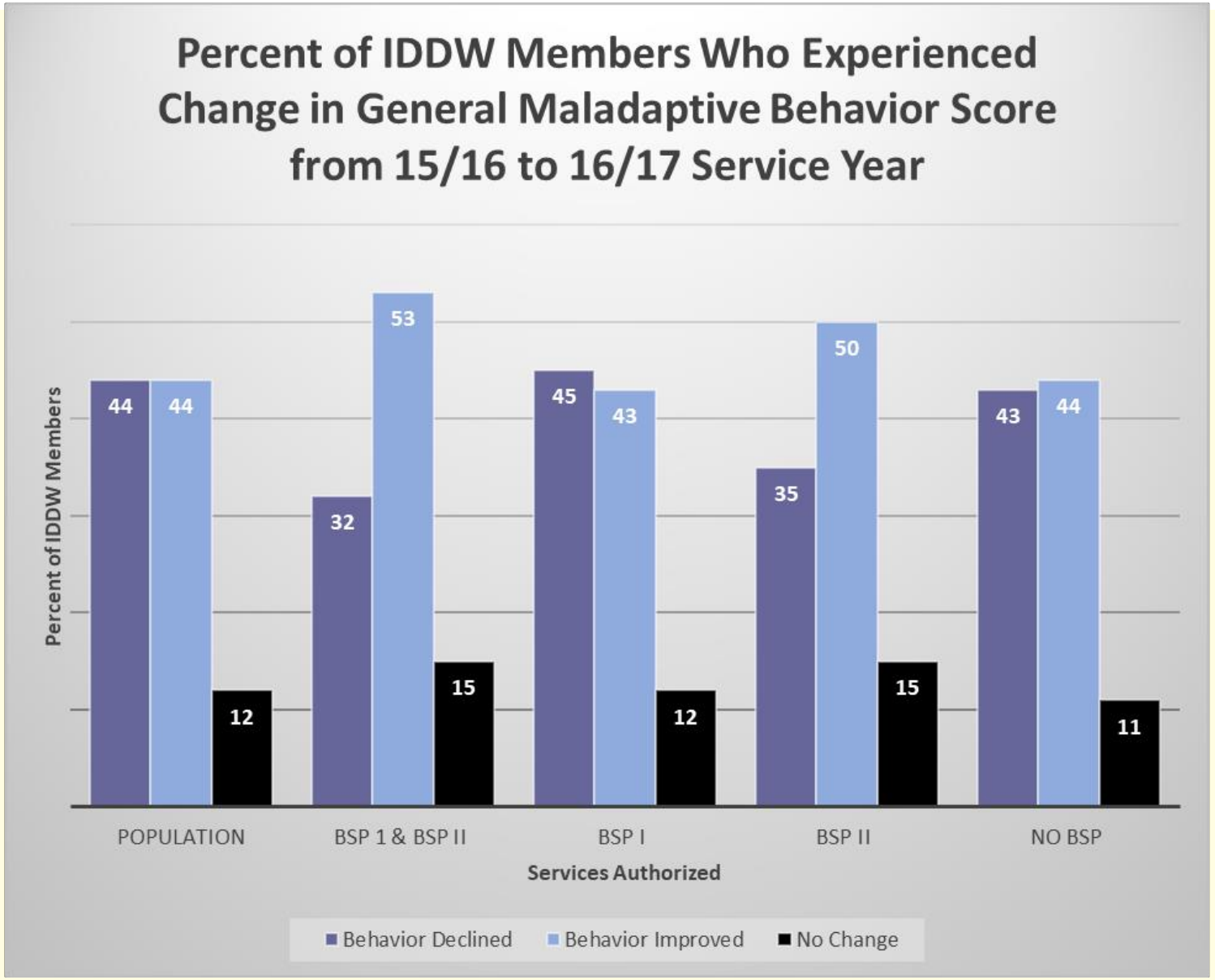
- BMS requested a year-to-year comparison of the General Maladaptive Behavior Index Score (GMB Score), which is the overall measure of maladaptive behaviors.
- The comparison includes percentages of individuals who experienced:
  - Decline in maladaptive behavior.
  - No change in maladaptive behavior.
  - Improvement in maladaptive behavior.

BSP Services Research (Cont.)

Sampling:

- 100% of program members who met the following criteria were reviewed:
  - Received an ICAP assessment sometime between July 1, 2015-June 30, 2016 **and again** between July 1, 2016-June 30, 2017.
  - Had active authorization for BSP I service for both service years **or** had active authorization for BSP II service for both service years.
  - Other criteria were reviewed as well such as those who had both BSP I and BSP II authorizations during that time period, and those who did not have authorizations for those services during the time period.
  - To allow for comparison, information was also gathered for the entire population who receive ICAP assessment during the timeframe identified above.

BSP Services Research (Cont.)



BSP Services Research (Cont.)

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Conclusion:

- Overall, little correlation can be made between the presence of BSP I, BSP II and improvement in maladaptive behaviors.
- When members had authorization for BSP services, behaviors increased at about the same rate as they decreased.
- When isolating BSP II services, it can be stated that a higher percentage of members improved as compared to other categories; however, this sub-set is a much smaller proportion of the population (only 109 of 4421 or 2% of the population measured had BSP II only).

Proposed Changes

- Change service limits to 250 annual units for members who live in Natural Family/Specialized Family Care settings.
- Change service limits to 350 annual units for members who live in ISS or Group Home settings.
- Merge BSP I and BSP II into one service code and establish a cost-neutral reimbursement rate.
- Strengthen policy for such BSP requirements as:
  - Clinical opinion in monthly summaries and other BSP activities,
  - Individuality of habilitation and behavior goals, and
  - Establish requirements for data collection and use of the service.

Stakeholder Input

- Take a moment to rate item ***1: "I think changing the BSP service limits from 768 annual units to 250 annual units for members who live in Natural Family/Specialized Family Care is a good idea,"*** on your survey.
- Circle one of the following options:
  - 1—Strongly Disagree
  - 2—Disagree
  - 3—Neutral/No Opinion
  - 4—Agree
  - 5—Strongly Agree
  - 6—N/A
- If you would like to provide any comments, please write them at the bottom or on the back of your survey.
- Would anyone like to offer their thoughts?

Stakeholder Input (Cont.)

- Take a moment to rate item ***2: "I think changing the BSP service limits from 768 annual units to 350 annual units for members who live in ISS/Group Home is a good idea,"*** on your survey.
- Circle one of the following options:
  - 1—Strongly Disagree
  - 2—Disagree
  - 3—Neutral/No Opinion
  - 4—Agree
  - 5—Strongly Agree
  - 6—N/A
- If you would like to provide any comments, please write them at the bottom or on the back of your survey.
- Would anyone like to offer their thoughts?

Stakeholder Input (Cont.)

- Take a moment to rate item ***3: "I think merging BSP I and BSP II into one service code and establishing a new rate is a good idea,"*** on your survey.
- Circle one of the following options:
  - 1—Strongly Disagree
  - 2—Disagree
  - 3—Neutral/No Opinion
  - 4—Agree
  - 5—Strongly Agree
  - 6—N/A
- If you would like to provide any comments, please write them at the bottom or on the back of your survey.
- Would anyone like to offer their thoughts?

Stakeholder Input (Cont.)

- Take a moment to rate item ***4: "I think strengthening policy for BSP requirements like clinical opinion, individuality of goals, and requirements for data collection would be a positive change,"*** on your survey.
- Circle one of the following options:
  - 1—Strongly Disagree
  - 2—Disagree
  - 3—Neutral/No Opinion
  - 4—Agree
  - 5—Strongly Agree
  - 6—N/A
- If you would like to provide any comments, please write them at the bottom or on the back of your survey.
- Would anyone like to offer their thoughts?

Proposed Policy Changes (as of July 1, 2020): Personal Options Services

Personal Options Services

Participant-Directed Goods and Services (PDGS):

- Public Partnerships, LLC (PPL), is the Fiscal/Employer Agent who manages the Traditional with Personal Options Service Delivery Model aspect of the I/DD Waiver program.
- Recently, PPL identified the most frequently requested items accessed via PDGS from 2015-2017.
- Of those items, 36% were items that can be accessed via Environmental Accessibility Adaptations (EAA), a service available to all I/DD Waiver members for the same dollar amount.
- Others, such as vision and dental services for children, and lift chairs, can be accessed via other state funded sources.

Proposed Change

- BMS proposes either eliminating the PDGS service, as the majority of items accessed can be accessed via other options, or
- Limiting it to the following items: Music therapy, vision, dental and gym membership. Home and vehicle modifications can be requested through EAA. These were the top items outside of EAA that have been utilized over the last 5 years. This suggestion came from a prior public comment period.

Stakeholder Input

- Take a moment to rate item ***5: "I think that PDGS should be eliminated altogether –or—I think PDGS should be limited to music therapy, vision, dental, and gym membership,"*** on your survey.
- Circle one of the two available options.
- If you would like to provide any comments, please write them at the bottom or on the back of your survey.
- Would anyone like to offer their thoughts?

Personal Options Readiness Assessment

- BMS and PPL have identified that some individuals who elect to participate in the Participant-Directed Service Delivery Model (SDM) option are unable to do so successfully.
- This may occur due to compliance or other issues.

Proposed Change

- To address potential compliance or other issues with participation in the Traditional with Personal Options SDM, BMS would like to introduce a Personal Options Readiness Assessment that will be used to identify whether a member is adequately prepared to, with his/her supports, successfully self-direct their services.
- The readiness assessment may also be used to evaluate active Personal Options participants to determine whether they are complying with program rules.
- If the readiness assessment indicates compliance or other issues, the participant may be required to transition back to Traditional Services.

Stakeholder Input (Cont.)

- Would anyone like to offer their thoughts or suggestions on implementation of this tool?
- If you would like to provide any additional comments, please write them at the bottom or on the back of your survey.

New Budget Methodology

-KEPRO

Why New Methodology?

There is a new methodology for calculating budgets for members on the I/DD Waiver.

- The old methodology was outdated.
  - Last updated prior to 2010.
  - Based on claims data from 2010.
  - The I/DD Waiver policy manual has changed two times since 2010, and amounts and types of services have changed.
  - The old methodology was not transparent, easily understandable or explained.

The New System and Process

Transparent and clear.

- BMS has developed a robust system with clear and detailed forms and notices for members who seek services in excess of their budgets by making changes to its processes, forms and notices.
- There is a new budget letter that will assign a budget range and will notify the member or his/her legal representative how the budget was calculated.
- There is a new form to request an exception in order to exceed the budget.
- 50 additional slots will be added to the I/DD Waiver on July 1, 2018.

The New System and Process (Cont.)

Accuracy.

- Third party actuaries studied thousands of claims from 2016 and developed a model that has a very high "R-Squared" predictive metric of .95. This means that the model's budget predictions, based on the claims data, align with 95% of what people currently enrolled in the I/DD Waiver spend.
- An actuary is someone skilled in mathematics, finance and analytical skills who deals with measurement and management of risk and uncertainty. The firm hired by BMS was a third party, meaning they were not involved in the situation or process of calculating budgets and authorizing services. BMS gave them the claims data, and they developed the model independent of any input or guidance from BMS.

The New System and Process (Cont.)

Individualized service authorization levels.

- The new system is highly individualized.
- The base budgets are calculated based on the person's individual characteristics, age and living setting.
- The person's individual characteristics of functionality (motor skills, personal living skills, externalized and asocial problem behavior) are considered when adding additional funds to the base budget.
- A review of the individual's spend for a 12 month period is used to calculate whether a member is eligible for the Stop Gain/Stop Loss Rule.
- The exceptions process will be unique as each person's circumstances are considered when the person's documentation is submitted for review.

The New System and Process (Cont.)

When will the new system and process begin?

- For any person on the I/DD Waiver as of March 1, 2018, the new methodology will be used to calculate their individualized budget for anchor dates of July 1, 2018, and later.
- Anyone with an anchor date prior to June 30, 2018, will still be assessed using the old methodology, but after that date they will be assessed using the new methodology.
- All new enrollees will receive budgets that are calculated using the new methodology.

What is New Methodology?

The new methodology is based on:

- The person's age (child, 18 and adult 18 or older).
- The person's living setting.
- Individual answers on the Inventory for Client and Agency Planning (ICAP).
  - The ICAP is a planning tool that has been used for years to assess a person's needs annually.

Age

There are two categories of age:

- Youth under the age of 18
- Adult 18 years of age or older

Living Settings

There are seven types of living settings:

- Youth (below 18) – living at home with family
- Adult – 18 years of age and living at home with family
- Adult – Intensively Supported Setting (ISS), Self-Directed
- Adult – Waiver group home, four people
- Adult – ISS x 3 people
- Adult – ISS x 2 people
- Adult – ISS x 1 person

Definitions of Living Settings

What does "living at home" mean?

- Living at home with family typically means living at home with parents, but it can also be defined as a specialized family care home for people in the foster care system. Paid and natural supports are used in these settings which means family, friends, neighbors and anyone who provides a service to the person but is not reimbursed. Normal parenting activities such as transporting the person to school, church, visit relatives or caring for a person who is absent from school or day services due to illness are considered natural supports.
- 75% of the people utilizing the I/DD Waiver live at home, therefore, natural supports are the primary means of providing support and supervision of these individuals.

Definitions of Living Settings (Cont.)

What does "living in a Intensively Supported Setting (ISS), Self-Directed" mean?

- This means the person has chosen to self-direct part of their services through *Personal Options.*
- The person or their program representative chooses the direct care staff and conducts the training, schedules and supervises staff, handles call-ins and absences as well as signs off on and approves time sheets and transportation invoices.
- The person or their program representative creates a spending plan with assistance from *Personal Options* staff and follows the spending plan when approving time sheets.
- The staff of *Personal Options* (currently Public Partnerships Limited (PPL)) handles all payroll functions and assists the person with self-directing their services.

Definitions of Living Settings (Cont.)

What does "living in an ISS" mean?

- ISS settings provide a home for up to three people or those utilizing the I/DD Waiver and provide most services 24 hours a day, seven days a week. No person may move into an ISS setting without the prior approval of BMS.
- A new one-person ISS may NOT be set up without the prior approval of BMS. If a person moves without permission to a more expensive setting without prior approval from BMS, services will not be reimbursed.
- These settings are typically apartments or houses that are leased by the individuals utilizing the I/DD Waiver. If the I/DD Waiver provider owns or leases the setting, then the provider charges the person rent that cannot exceed the amount in the current Medley Management Policy on room and board.

Definitions of Living Settings (Cont.)

What does "living in a group home (GH)" mean?

- These are apartments or houses that are owned by the I/DD Waiver provider agency and are licensed by the Office of Health Facility Licensure and Certification, and services are provided 24 hours a day, seven days a week. A new one-person GH may NOT be set up without the prior approval of BMS. If a person moves without permission to a more expensive setting without prior approval from BMS, services will not be reimbursed.
- A GH can be for up to four or more people utilizing the I/DD Waiver. No new settings of more than four people will be reimbursed for services provided.
- The setting has to be licensed by the Office of Health Facility Licensure and Certification if more than three people are living together at anytime.

What is the Next Step?

Once the person's age and living setting have been identified, the next step is for KEPRO to assign a base budget to provide for all I/DD Waiver services for the person's Individual Program Plan (IPP) year.

Living Arrangement Categories	Low-End	High-End
Youth (Below 18) Living at Home with Family	$29,643	$33,081
Adult: Living at Home with Family	$38,283	$44,231
Adult: ISS Self Directed	$82,519	$94,830
Adult: Waiver Group Home, Four People	$78,540	$85,687
Adult: ISS x 3 People	$104,318	$110,027
Adult: ISS x 2 People	$123,279	$128,562
Adult: ISS x 1 Person	$176,731	$182,507

Add-Ons

The next step is to review the most current ICAP assessment and determine if the person's budget should receive any additional funds based on the ICAP scores. These are called add-ons. Service Coordinators will have the person's unscored ICAP booklet so that the IDT team may review the questions and answers. It is the responsibility of the people answering the questions to be accurate and honest. The booklet will be kept in the person's clinical file.

There are add-on amounts for four different categories in the ICAP:

- Motor skills
- Personal living
- Externalized problem behavior
- Asocial problem behavior

Motor Skills Add-On

Depending on the raw scores in the Motor Skills section of the ICAP (D1), the person may be eligible for additional monies to be added to the base budget range.

The below table shows the add-ons for the Motor Skills section:

Motor Skills	Member Level	Add $
If Raw Score = 39-54	0	$0
If Raw Score = 33-38	1	$1,459
If Raw Score = 27-32	2	$2,918
If Raw Score = 15-26	3	$4,377
If Raw Score = 1-14	4	$5,836

Personal Living Skills Add-On

Depending on the raw scores in the Personal Living Skills section of the ICAP (D3), the person may be eligible for additional funds to be added to the base budget range.

The below table shows the add-ons for the Personal Living Skills section:

Personal Living Skills	Member Level	Add $
If Raw Score = 37-63	0	$0
If Raw Score = 30-36	1	$1,233
If Raw Score = 23-29	2	$2,466
If Raw Score = 12-22	3	$3,699
If Raw Score = 0-11	4	$4,932

Externalized Problem Behavior Add-On

There is an add-on for externalized problem behavior based on select answers on the person's ICAP.

- If the person has a rating of extremely serious or very serious on questions E2, E3 or E4, then an add-on amount total of $4,287 will be added to the base budget range.
- If the person has a rating of moderately serious or slightly serious on questions E2, E3 or E4, then an add-on amount total of $2,968 will be added to the base budget range.
- If the person has a rating of very or extremely serious for one of the questions and a moderately or slightly serious rating on another question, the higher of the two add-on amounts will be added to the base budget range.

Asocial Problem Behavior Add-On

There is an add-on for asocial problem behavior based on select answers on the person's ICAP.

- If the person has a rating of extremely serious or very serious on questions E6 or E8, then an add-on amount total of $3,840 will be added to the base budget range.
- If the person has a rating of extremely serious for one of the questions and a very serious rating on the other question, the higher of the two add-on amounts will be added to the base budget range.

Externalized and Asocial Problem Behavior

Externalized Problem Behavior	**Add $**
If one or more of ICAP E2, E3 or E4 severity rating=	
• Extremely serious or very serious	$4,287
• Moderately serious or slightly serious	$2,968
Asocial Problem Behavior	**Add $**
If one or more of ICAP E6 or E8 severity rating=	
• Extremely serious or very serious	$3,840

Youth <18 Living at Home with Family

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Example One	Low-End	High-End
Youth (Below 18) Living at Home with Family	$29,643	$33,081
Add-ons		
Motor Skills Level = 2 (Raw Score = 28)	$2,918	
Personal Living Level = 3 (Raw Score = 21)	$3,699	
ICAP E2 = Not Serious	$0	
ICAP E3 = Not Serious		
ICAP E4 = Not Serious		
ICAP E6 = Slightly Serious	$0	
ICAP E8 = Not Serious		

Youth <18 Living at Home with Family (Cont.)

- Member's budget range of $29,643 - $ 33,081 will now be changed to reflect a range on the budget letter of $36,260 - $39,698 because the two add-ons total up to $6,617 ($2,918 + $3,699).
  - $29,643 + $6,617 = $36,260
  - $33,081 + $6,617 = $39,698
- There is one more rule that needs to be applied before KEPRO can send the annual budget letter out to the member.
  - This is known as the Stop-Loss/Stop-Gain rule.

What is the Stop-Loss/Stop-Gain Rule?

- The Stop-Loss/Stop-Gain Rule was developed to ease the transition from the old budget methodology to the new budget methodology.
- The Stop-Loss Rule is applied when the person's spend is higher than the upper range of the tentative budget so the person doesn't lose very much below their previous spend.
- The Stop-Gain Rule is applied when the person's spend is lower than the upper range of the tentative budget so that person doesn't gain too much over their previous spend.
- The Stop-Loss/Stop-Gain Rule will cease to apply if the person's circumstances change, as measured by a significant change in the ICAP score.

Stop-Loss Rule

- Under the Stop-Loss Rule, a person who is enrolled in the I/DD Waiver program on March 1, 2018, will receive no less than 80% of his/her spend from December 1, 2016, to November 30, 2017, or the upper limit of the tentative budget range. Each person with a spend from December 1, 2016, to November 30, 2017, that is higher than the top range of the tentative budget will receive the higher of:
  - The budget assigned through the new budget system; or
  - 80% of his/her December 1, 2016 to November 30, 2017 spend.

Stop-Gain Rule

- Under the Stop-Gain Rule, a person who is enrolled in the I/DD Waiver program on March 1, 2018, will receive no more than 120% above his or her spend from December 1, 2016, to November 30, 2017, or the upper limit of the tentative budget range. Each person with a spend from his/her December 1, 2016, to November 30, 2017, claims that is lower than the highest range of the proposed tentative budget will receive the lower of:
  - The budget assigned through the new budget system; or
  - 120% of his/her December 1, 2016 to November 30, 2017, spend.

What is My Spend?

- A person's spend consists of the actual claims that were paid for I/DD Waiver services which were provided for any date between December 1, 2016, and November 30, 2017.
- How will KEPRO know what a person's spend was for this time period?
  - BMS will have a copy from claims payer Molina Medicaid Solutions that will be shared with KEPRO to assist in calculating each person's individualized budget. We used the time period of December 1, 2016, to November 30, 2017, in order to get the most accurate amount of paid claims submitted prior to the implementation of the new budget methodology for assessments completed on and after April 1, 2018.
- How will I know what my spend was for this time period?
  - It will be printed on your budget letter as the amount you are projected to spend.

Stop-Loss/Stop-Gain Calculation

Example One: Youth (below 18) Living at Home with Family

- Determine if the Stop-Loss/Stop-Gain Rule needs to be applied.
- After the add-on amounts, the youth now has a tentative budget range of $36,260 - $39,698.
- The actual spend for this youth last year was $29,057.38.

Stop-Loss/Stop-Gain Calculation (Cont.)

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Example One: Youth (below 18) Living at Home with Family

- The actual spend for this person ($29,057) is below the upper range of the tentative budget ($39,698); therefore, the Stop-Gain Rule is applied to ensure that the person does not receive a budget that is far more than their previous spend.
- If $29,057 is less than $39,698, the Stop-Gain Calculation is applied.
- $29,057.00 x 120% = $34,868.
- Which is the lower of the amounts?
  - $34,868 is less than $39,698, so the person's individualized budget's top range will be $34,868.
  - The new budget range for this person will be $29,057 to $34,868.

Adult Living at Home with Family

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Example Two	Low-End	High-End
Adult >18 Living at Home	$38,283	$44,231
Add-ons		
Motor Skills Level = 1 (Raw Score = 33)	$1,459	
Personal Living Skills Level = 3 (Raw Score = 17)	$3,699	
ICAP E2 = Moderately Serious	$2,968	
ICAP E3 = Not Serious		
ICAP E4 = Moderately Serious		
ICAP E6 = Slightly Serious	$0	
ICAP E8 = Slightly Serious		

Adult Living at Home with Family (Cont.)

- The add-ons for this person totaled $8,126, so the budget range will now be calculated as $46,409 to $52,357.
- This person's spend was $60,800.
- This person's spend of $60,800 is more than the upper range of the budget which is $52,357 so the Stop-Loss rule will apply.
- 80% of $60,800 is $48,640.
- $48,640 is less than $52,357, so the final budget range is $46,409 to $52,357.

Stop-Loss/Stop-Gain Rule Summary

- If the person's spend is less than the upper limit of the budget range, then the Stop-Gain Rule is applied (120% of the spend).
- Once the rule is applied and 120% of the spend is compared to the upper limit of the budget, then the lower amount becomes the upper limit of the budget.
- If the person's spend is more than the upper limit of the budget range, then the Stop-Loss Rule is applied (80% of the spend).
- Once the rule is applied, then the higher amount becomes the upper limit of the budget.
- More examples from each of the different living settings with the Stop-Loss or Stop-Gain Rule applied are posted on the BMS website: http://www.dhhr.wv.gov/bms

Exceptions Process

- If the person's final budget range using the new budget methodology is still not enough to meet their needs, they may access the Exceptions Process.
- This replaces the previous Second Level Negotiation process.

Exceptions Process (Cont.)

- When is it appropriate to access the Exceptions Process?
  - The Interdisciplinary Team (IDT) has an obligation to make every attempt to purchase services it deems are necessary within the person's individualized budget.
- After careful consideration, if the person or his/her legal representative believes services in excess of budget are needed, then an additional section of the Individualized Program Plan (IPP) must be completed.
- Any individual requesting services in excess of the budget must complete the initial section of the IPP that requests services *within* budget. Individuals must prioritize requests for direct care services in this section. No services in excess of the budget will be approved until this initial section is complete and the services are approved by BMS.

Exceptions Process (Cont.)

- The Exceptions Process request will be clinically researched by a panel of a three people employed by BMS and its contractor (currently KEPRO).
- At least one person on the panel will have medical training.
- First, the panel will determine if any technical errors were made in the calculation of the budget range.
- Next, the panel will review the documentation submitted by the service coordinator on behalf of the member to determine if funds in excess of the budget are needed to purchase clinically appropriate services necessary to prevent a risk of institutionalization.

Exceptions Process (Cont.)

- The person seeking additional services through the Exceptions Process has the burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization.
- A clear explanation must be made to the panel justifying why the additional services are needed.
- Any documents must be attached/enclosed/provided to the panel and the specific sections highlighted. Just referring to attached documents on the Exceptions Process form is NOT sufficient and will not be considered by the panel.
- Some documents must be attached to the request.

Exceptions Process (Cont.)

The documents that MUST be attached to the Exceptions Process form are:

- The most recent ICAP printout from the CareConnection®
- The most recent structured interview
- All IPPs from the current IPP year

Exceptions Process (Cont.)

Additional information the panel will consider include:

- Any information provided by the person in his/her application for an exception.
- The feasibility of rearranging services within the person's budget.
- The availability of less expensive services that can be substituted for more expensive services.
- The availability of services covered outside the I/DD Waiver program by Medicaid or by private insurance.
- The natural supports (if any) available to the person and limitations on those supports.

Exceptions Process (Cont.)

- If BMS concludes that the person has demonstrated that funds in excess of the individualized budget are necessary to prevent a risk of institutionalization, BMS will authorize funds in excess of the budget to the extent necessary to keep the person safe and healthy and avoid the risk of institutionalization.
- If BMS determines that the person did not demonstrate funds in excess of the individualized budget are necessary to avoid the risk of institutionalization, BMS will not authorize funds in excess of the budget.
- If BMS determines that an error was made in the budget calculation process, it will take steps necessary to correct the error.

Exceptions Process (Cont.)

- If BMS determines that there was not an error during the Exceptions Process, or that the requested additional services and funding are not warranted, a Letter of Denial will be sent to the person or their legal representative, which will include an explanation of why the service(s) and funding were denied, how to file for a Medicaid Fair Hearing (MFH) and free legal services available. All decisions during the Exception Process shall be reviewed and/or issued by BMS.

- A person will have the ability to appeal the denial of a request for an exception through a MFH. The hearing officer will apply the same standard applied by BMS's exception panel, i.e., whether the person has met his or her burden of showing that services in excess of the individualized budget are necessary to avoid the risk of institutionalization.

Questions and Wrap-Up

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