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March 5, 2018

Mark Drennan, Executive Director
West Virginia Behavioral Health Care Providers Association
405 Capitol Street, Suite 900
Charleston, WV 25301

RE: BHPA's Comments on I/DD Waiver Individual Budget Authorization Process

Dear Mr. Drennan:

Thank you for contacting our office regarding your comments concerning the change of the service authorization methodology and process for the Intellectual/Developmental Disabilities ("I/DD") Waiver. The West Virginia Department of Health and Human Resources ("DHHR"), Bureau for Medical Services ("BMS"), appreciates your support of our West Virginia Medicaid population.

We have carefully reviewed the report that Health Management Associates ("HMA Report") prepared for the Behavioral Health Providers Association in response to the proposal of the DHHR to change the service authorization methodology and process for the I/DD Waiver. We appreciate the time and effort that went into the report and would like to take the opportunity to respond.

At the outset, we appreciate that the HMA Report identifies several strengths and opportunities in the new model, especially as compared with the prior system. Among other things, we agree that strengths of the model include that it is developed by certified actuaries based on reliable data, and that its components are easily understood and tracked.

We would like to address the seven (7) areas that HMA identified as of "significant risk."

1. HMA believes there is a risk of a "downward spiral effect" on individual budgets. The basis for this assumption appears to be that the individual budget is based "on the individual's expenditures from a limited previous time." HMA Report at 7. This is not correct. The individual budget is not based on the individual's own expenditures in a prior year, but rather on the range of expenditures in the base year for adults or children in a particular living setting with a particular Inventory for Client and Agency Planning ("ICAP") score. Individual departures from expected spend – for example, if a

service was" not delivered because an appropriate provider was not available" – would have a negligible impact on the overall range associated with each group and, in the aggregate, would likely be counterbalanced by expenditures more than budget because of the enhanced exceptions process.

2. HMA states that the model fosters a system in which "the risk for the cost of obtaining services within the determined budget shifts from the state to the beneficiary." This is incorrect. It has always been DHHR's policy that it is the responsibility of the IDT Team to propose services within an individual's budget, and it has always been the responsibility of the member to establish that services in excess of the budget are necessary. In the past few years, DHHR has been more rigorous in reviewing such requests to ensure that substitute services cannot be used, and that the requested services are necessary to avoid institutionalization.

3. HMA is concerned that the exceptions review process "has no mandatory timelines and thus may leave the member waiting without sufficient services while the request is being considered." DHHR agrees that the exceptions process should include clear "timeliness standards" for decisions made by the three-person review panel. In response to this and similar comments, DHHR amended the I/DD Waiver Manual to require the Exceptions Panel to make decisions "within 20 business days after the Exceptions Panel has received submission explaining the basis for the exceptions request with any/all supporting documentation."

4. HMA is concerned that the "stop gain" provision may prevent an individual from accessing a budget that is sufficient for a member's needs. DHHR is aware that this is a risk of the provision, but concluded that on balance the stop gain and stop loss provisions would help smooth the transition from the prior model to the new model. DHHR recognizes that if an individual's needs change substantially (requiring a greater than 20% increase in services over the prior year) that the stop gain provision should not artificially limit the new budget. One way to establish changed need would be a change in the ICAP score. Another way would be through the enhanced exceptions process. DHHR believes both available avenues greatly mitigate the identified risk.

5. HMA states the ICAP assessment tool is not a good basis for cost allocation and does not fully reflect individual needs, and that it is not "transparent or simple to understand." Several States use the ICAP to determine service levels; it is a tool which is familiar to West Virginia case workers and families; and the Lewin Group was able to use the data from prior ICAP assessments and service levels to try to more accurately predict service level needs. The ICAP is certainly more transparent and easier to understand than the current system, which is the subject of a lawsuit.

The new model add-on amounts were determined based on the regression model developed from the most significant ICAP variables for predicting actual spending in fiscal year 2016. Individuals who fall outside the norm can go through the exceptions process to obtain additional services. In the future, DHHR intends to gather data from the

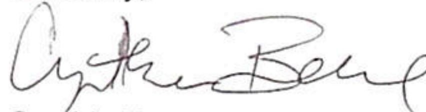
exceptions process to determine whether the information from the ICAP should be supplemented or replaced in the next phase of recalibration.

6. HMA says that the model raises questions regarding the use and application of the person-centered planning process to support individual choice and independence in living setting. DHHR remains committed to person-centered planning and to supporting adult waiver members who desire to live independently, even though these are the most expensive waiver services and the cost far exceeds the cost of ICF/IID services. Nor does the new model impede the ability of waiver members to change living settings over the course of the year. Under the new model, as before, an individual can seek a critical juncture meeting review services and, if necessary, request additional services.

7. Finally, HMA concludes that the model has the "potential" to be out of compliance with waiver assurances, including "budget neutrality and the ability to ensure member's health and safety in an integrated care and person-centered planning environment with reduced individual budgets." The basis of this statement appears to be that the base year used to determine budget ranges and add-on amounts is the 2016 base year, in which DHHR, in accordance with a waiver provision reviewed and approved by CMS, implemented certain service caps. Since those caps were implemented, DHHR has carefully monitored admissions to long-term care facilities and incident reports to ensure that its waiver assurances remain accurate. It will continue to do so under the new model.

Thank you again for your comments. Please do not hesitate to contact us if you have any further questions or concerns.

Sincerely,



Cynthia Beane, MSW, LCSW
Commissioner

Cc: Kim Stitzinger, General Counsel, Attorney General's Office
Patricia Nisbet, Program Director, Home and Community-Based Services

HMA

HEALTH MANAGEMENT ASSOCIATES

West Virginia Intellectual/Developmental Disabilities Waiver Individual Budget Authorization Process

PREPARED FOR
THE WEST VIRGINIA BEHAVIORAL HEALTH PROVIDERS ASSOCIATION

BY
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DATE
DECEMBER 18, 2017

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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I. Executive Summary:

The West Virginia proposed Intellectual/Developmental Disabilities Waiver (IDDW) individual budget authorization process addresses the concerns raised in the current lawsuit regarding individual budget calculations, but it presents significant challenges in the areas of person-centered planning, 1915(c) home and community based waiver assurances, integrated home and community based long term services and supports, and the ability to sustain a stable workforce for the IDD population. The new model may provide more transparency and clarity than the current proprietary computer-generated algorithm that determines individual budgets. The lack of such clarity was a major complaint among members and their families. However, the proposed model is based upon age, living setting, and a point-in-time service spending rather than an assessment of individual need as determined by a *comprehensive* functional needs assessment of the individual, regardless of living situation. The proposed model was also developed without input from current members, families, providers, and other stakeholders. While these groups have been trained about the model, engaging them in the selection and development would likely have provided more transparency and clarity, as required in the court order. While the proposed model provides monetary add-on, provisions based on certain known personal characteristics as cost drivers, such as challenging behaviors and complex care needs, the base funding allocation is not based on the needs of the individual member and is derived solely from service spending in the base year. Both current and proposed models afford members access to an exception review process for individual circumstance; however, the lawsuit also raised concerns about the timeliness and accuracy of the individual budget appeals process. Currently, clinical reviews are not being completed on a timely basis. It remains to be seen if the new process will correct this problem. There does not seem to be a clear path for further appeal. Although the proposed model calls for the review by a three-person panel (including at least one clinician) instead of a one-person review, there are no new or mandatory requirements that address timeliness, transparency, or quality.

The proposed model, as designed by the Lewin Group, expects to serve most waiver participants (65%) within the same funding range available and received today and predicts 95% accuracy compared to historical expenditures in the base year (2016). If accurate, this promotes a degree of stability year over year, but does not necessarily address individual need each year or over time. While several states implement relatively similar models, HMA recommends that the state address the challenges summarized above and detailed throughout this paper to ensure this process is a feasible alternative for West Virginia and West Virginia waiver participants.

HMA has identified six areas of significant risk with the proposed model:

- The model has an inherent risk of **downward spiral effect** on individual budgets, which will most likely result in a reduction in budgets each year. An expenditure-based calculation calculates only what is spent, not what is needed. Any circumstance creating less than expected utilization of waiver services, such as inpatient hospitalization, staffing shortages, or other circumstances could create a variation from what is assessed as needed, budgeted and delivered, and what is expended. As the methodology is updated for each prior year spend, this is likely to have a negative effect on individual budgets based upon *spend*, not *individual need*.

- The model fosters a system in which the risk for the cost of obtaining services within the determined budget **shifts from the state to the beneficiary.** Rather than the use of an appropriate needs assessment and proper care planning by the state to authorize services to keep individuals healthy and safe in their preferred living arrangement, the model determines an upper limit based primarily on the amount spent in the prior year (with challenges noted above), and the risk falls to the beneficiary to prove that this amount is inadequate. Stakeholders have voiced concerns regarding the exception review process and member rights to fair hearings; reporting that many individuals have been denied fair hearing rights over the prior spend year. These individuals' budgets may place members at risk for insufficient services and supports not due to their actual need, but due to their fair hearing requests having never been resolved.
- The proposed model provides an **exception review process** for members to request a review of their individual situation when they believe that the model did not provide a budget that is sufficient to obtain services to meet the member's needs. However, this process has no mandatory timelines and thus may leave the member waiting without sufficient services while the request is being considered. Stakeholders report that many times in the past members have waited up to six months or more for a review to be completed, and there is no guarantee that this will not happen with the new system. Clear and transparent standards for evaluating the exception review process should be developed, published, and regularly monitored to ensure that the process is effective, appropriate and reflects independent clinical judgement of need.
- The model's **stop-gain provision**—which specifies that the individual cannot receive a budget that is more than 120% of their previous year's budget, may be subject to federal review of appropriateness and approvability of the waiver amendment. Placing an upper limit on the individual budget is likely to reinforce individual risk, to reinforce the downward spiral budgetary effect, and to raise questions regarding the clinical appropriateness of the assessment methodology. The West Virginia Department of Health and Human Resources presentation regarding the "New Budget Methodology and Service Utilization Process" states that 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". No additional definitions or operational details are offered regarding how this will be implemented. It should also be noted that the proposed new methodology only assesses four categories in the ICAP for capped add on payments. These areas are: Motor Skills, Personal Living, Externalized Problem Behavior, and Asocial Problem Behavior.[1] The methodology does not clearly state how add on amounts are determined to be sufficient for each member's needs. There are no other financial add-ons for other needs specific to each member; including medical needs.
- The model's **use of the ICAP** as an individual cost allocation tool is not transparent or simple to understand. The ICAP is an assessment and planning tool that does not adequately account for behavioral deficits. The state has indicated that the assessment tool does not fully reflect individual needs. The stated purpose of the ICAP is to "aid in screening, monitoring, managing, planning and evaluating services [for persons with developmental disabilities]." A common use of the instrument is to assist users (service providers, regional authorities, and state agencies) to

[1] Intellectual and Developmental Disabilities Waiver (IDDW): New Methodology and Service Authorization Process, West Virginia Department of Health and Human Resources Bureau for Medical Services; Nesbit, Patricia. October 31, 2017.

compile standardized profile information about individuals who receive services. The instrument was not developed to support rate determination or individual resource allocation strategies, although it has been employed by several states for such purposes.[2]

- The model raises questions regarding the use and application of the **Person-Centered planning process** to support individual choice and independence in living setting**.** The financial model may create arbitrary barriers or disincentives for use of appropriate integrated settings or the movement across settings based upon financial base budget assumptions. The proposed model relies on age and individual living situation to establish the base budget range before applying potential ICAP category "add-ons". The base budget range for adult and youth categories are less than half of the next higher level of support for not living with family. The lawsuit raised concerns that the system includes an unrealistic expectation about the ability of families to provide uncompensated care for the member; expectations that appear to be continued in the new methodology. It is not clear how the new model will support planned and unplanned changes in living setting, including the choice of members to seek more independent living opportunities, during the budgeted year.
- The model has a potential to **be out of compliance with waiver assurances,** including budget neutrality and the ability to ensure member's health and safety in an integrated care and person-centered planned environment with reduced individual budgets.

Apart from the proposed model's viability, there are important issues to consider to ensure the success of the new individual waiver budget authorization system. These include the impact on members and their families, service providers, and the waiver program at large. The model also may affect the state's ability to meet the waiver assurances and to comply with the federal waiver regulations. Our analysis indicates that this model has the potential for tighter controls on service spending but provides a structure and procedure that appear feasible only in the short term. In the first year of implementation, individual budgets that may have not been appropriately updated in accordance with individual's need may be successfully adjusted under this new system. However, the rightsizing will still be based on the prior year's spending and not on the individual's assessed functional needs. In fact, in the long run, the model may result in individual budgets that are insufficient to sustain the level of services needed for the individual to live safely and independently. Because the model relies so heavily on prior year individual spending, we recommend the new authorization process be closely monitored and reevaluated. The system re-evaluation should be part of a transparent, coordinated, and on-going quality improvement process that includes participation by beneficiaries and key stakeholders. In review of the new system, stakeholders have noted that, while there have been numerous opportunities to be trained on the new model, they have not been given any opportunities to provide input to help identify strengths and weaknesses of the new model and its implementation. There is skepticism about the effectiveness and independence of the exception review process. Given these concerns, it would be prudent to pilot and evaluate this budget methodology with a representative sample of waiver enrollees

[2] Background information about the ICAP, its development and applications is available at cpinternet.com/~bhill/icap/

and provider types, which would provide opportunities to refine the methodology before using it for the entire waiver population.

II. Approach:

The Center for Medicare and Medicaid Services (CMS) defines an individualized budget as the amount of funds that is under the control and direction of the individual. The budget plan is developed using a person-centered planning process and is individually tailored in accordance with the individual's needs and preferences as established in the service plan. States must describe the method for calculating the dollar values of individual budgets based on reliable costs and service utilization, define a process for adjusting the budget when changes in participants' person-centered service plans occur, and define a procedure to evaluate participants' expenditures.[3] Using this definition as a guide, Health Management Associates, Inc., (HMA) conducted an independent review and analysis of the West Virginia proposed model for the proposed individual waiver services budget authorization process.

HMA reviewed publicly available information including the explanation of proposed model methodology submitted in Exhibit 1 of the court document,[4] the section of the West Virginia waiver provider manual that explains individual budgets, comments and replies from previous changes to the IDDW, copies of proposed member notices for the new system, a PowerPoint presentation by the state to the provider industry, the Inventory of Client and Agency Planning (ICAP), comments, and responses regarding the 2015 Statewide Transition Plan, and the most recent IDDW amendment. HMA also spoke with a variety of leaders from the waiver provider community and advocates and stakeholders representing the interests of participants of the IDDW program. Additionally, HMA interviewed former federal staff from the Association for Community Living regarding state trends in individual waiver budgets and assessment processes. The objective was to glean information from states with IDD waivers regarding their experience and lessons they learned and to identify similarities or differences regarding waiver participants' individual budgets for comparison to West Virginia's new process. Using the information gathered, HMA conducted a strength, weakness, opportunities and threats (SWOT) analysis of the West Virginia IDDW individual budget authorization process proposed under the new model.

The recommendations and conclusions provided are limited to HMA's specific scope of work, the availability of public documents, and key informant feedback.

[3] CMS HCBS waivers https://www.medicaid.gov/medicaid/ltss/self-directed/index.html

[4] Court document "Exhibit 1; Service Authorization System: case 2:15-cv-09655; Document 155-1; Filed 05/12/17; Page 1 of 30 Page ID#:2172

III. Analysis:

A. Budget Model's Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

STRENGTHS:

As Identified by The West Virginia Department of Health and Human Resources (WEST VIRGINIA DHHR or "the department")

The department identifies three major attributes of the proposed budget authorization system. The system offers transparency and clarity for members, improved detailed forms for members to request increased budgets through the exception review process, and informational notices to members to explain the results of the exception review and the way their budgets were calculated. The department states that the proposed IDDW (minimum and maximum) budget amounts are accurate and adequate because they were based upon the most recently available data (2016 claims) that shows waiver expenditures as calculated by certified actuaries. The department indicates that the Lewin Group found that the model produced a predictive metric of 95% accuracy compared to historical expenditures in the base year (2016). The final strength cited by the Department is that the new system is more highly individualized. It calculates each member's budget based on the setting where they live and the functionality score on certain questions from the ICAP assessment tool. Additionally, an exception review process provides a way for members to seek an even more individualized review if the calculated budget amount is not sufficient to meet their needs for waiver services.

As Identified by HMA

HMA reviewed the characteristics of the proposed budget authorization system and determined the system to have the following strengths.

- The new process considers different factors in setting budgets for youth and adults.
- The individual's functional capabilities are considered as a basis for adding additional resources to the base budget. ICAP scores for behaviors, motor skills, and personal living skills are used to allocate additional resources where indicated to address patient needs.
- Previous expenditure data is reliable, as it is from actual claims submitted and paid.
- Administrative processes and communication with members may improve under the new system because the process for communicating with members has been revised and is more detailed.

WEAKNESSES:

HMA identified components of the proposed budget authorization system that are problematic. Further efforts may be required to correct weaknesses. Revisions to the policy or the procedure for implementation may be required or a decision to use a different model may be necessary.

- The model formulates an individual budget based on the individual's expenditures from a limited previous time (2016 base year). This is problematic because the past-year expenditures may not accurately reflect the individual's current and planned service needs. For example, a member may have an identified need for a service that was not delivered because the appropriate provider was not available. In that instance, the spending level is less than planned, but that level does not accurately reflect the need for services. Conversely, the base-year

expenditures may be unusually high because the individual needed a high level of services in that base year that is not reflective of the person's ongoing needs. Under this proposed system, the amount the individual spends on waiver services from a previous 12-month period is key to setting the individual's base budget. If anticipated utilization is based primarily on actual spending in the base year, this component of the reimbursement structure may not reflect actual needs. This could lead to artificial inflation or under-estimate of individual budgets. The consequence would be that both individual needs and the needs of the total waiver population might not be appropriately met. Actual spending is a critical data element, but it should be balanced with individual needs assessment and person-centered planning for setting individual budget ranges.

- The proposed budget authorization process does not consider a member's specific functional need for waiver services in terms of amount, scope, and duration. The base budget without any add-on calculation; accounts for only age, living situation, and previous service expenses. For someone who does not have sufficient deficits in behaviors or adaptive behaviors to qualify for an add-on amount, the amount may be insufficient to meet their functional needs. For example, for a member who does not have the scores required on the ICAP to receive an add-on amount to their individual budget but still has above-average needs, the member's budget, which would be based solely on age, living setting, and previous years' service expenditures, would not be adequate to meet their individual functional need for services—how much, to what degree or intensity and for how long. While the ABAS II and structured interview process are part of annual assessments, the new methodology does not clearly indicate whether or how these processes impact individual budgets.
- The only information scores used from the ICAP are about behaviors, motor skills, and personal living skills. In this model, the functional assessment is used only to determine the need for additional funds. However, the assessment tool being used as the basis for the additional funds, called an "add-on" amount, is not designed to measure acuity for the purpose of establishing *cost of care*. For example, when the ICAP indicates a deficit in adaptive behavior, it is referring to the severity of the need, not the price of care. Therefore, it is a weakness of this model to rely on a tool that was designed for service planning as a way of estimating of the cost of those services.
- The model includes a stop-gain/stop-loss provision which offers some protection to the member in cases where there are significant differences in the amount of money the member has been allocated in the past and the amount that is needed in the present. However, a weakness in the proposed system is that the baseline was developed from a time in which expenditures were reported to be lower than normal following other budget driven policy initiatives. This highlights the potential consequences of over-reliance on past expenditures to determine the calculation. Using a known lower base period to establish ranges could artificially depress the upper limit of individual budgets. In addition, an ongoing cap on the upper range limit will likely have the net effect of lowering expenditures over time regardless of need, creating the "spiral down" effect that will most likely tend to be reinforced with each rebasing.
- There does not seem to be a provision to ensure that the exceptions review process yields timely or fair determinations. HMA recommends this process be transparent with published definitions and review criteria, including timeliness standards, so that members and providers alike can

understand how, by whom, and within what timeframe the exception will be determined and how this process will be monitored and evaluated.

OPPORTUNITIES/POSITIVE ASPECTS:

The proposed budget authorization process does provide a budgeting structure to reach the outcomes the state is seeking to provide its members and providers. There are many positive opportunities in this model that should be monitored after implementation and further refined to be consistent with the goals of the West Virginia Medicaid IDDW program. HMA identified several opportunities in this analysis that suggest that the model encourages and promotes a reasonable understanding of the connection and balance between the members' needs and the providers' ability to meet those needs in an economically efficient manner. The opportunities the model presents are expressed in the details of the authorization process.

- The proposed model was developed by certified actuaries who studied the current spending for the IDDW program and developed a base budget methodology that is highly predictive with previous spending for the majority of waiver enrollees. The actuary used predictive drivers of cost such as a member's age and the setting where services are delivered. For individuals with significant aberrant behaviors and/or deficits in adaptive behaviors, the proposed model identifies certain questions from the functional assessment as a basis for determining the provision of additional resources to support these needs. And finally, the previous expenditures for waiver services were used in the calculation for the base budgets, providing a degree of stability and predictability in calculating likely future service needs/expenditures.
- Although some situations of congregate living require prior authorization by the Medicaid Agency, the proposed individual budget model is based on the following age and setting categories:
    - Age <18 or >18+
    - Living setting
        - Youth living at home
        - Adult living at home with family
        - Adult ISS self-directed
        - Adult waiver group home 4 people
        - Adult ISS x3
        - Adult ISS x2
        - Adult ISS 1:1

  This data is easily attainable and consistent with how the waiver program is managed. The department can use existing systems to establish base individual budget amounts, which should decrease administrative expense.
- The model has components that are easily understood and tracked. Age and living setting are clearly defined. This is a data opportunity that is not always recognized in every state.

- There is an opportunity to monitor and further understand the cost of care for individuals participating in HCBS. The state will have the ability to capture additional service cost related to certain behaviors and certain adaptive skills. This information will help refine the 1915c waivers and document cost savings between HCBS and institutional services and supports. Many systems do not allow for additional cost associated with services, the need for which is often unpredictable because of the individual's unique circumstances and variations in professional clinical judgement. An example is behaviors that require one-on-one intervention, then supervision, then professional consultation regarding how to deescalate behavior. Usually, the scope, intensity, and duration of services is not known until the behavior occurs, and each situation is different. The availability of the additional resources will be very valuable for future waiver amendments and strategic initiatives for this population, including evaluation of the proposed new methodology.
- The model begins to set a path to seek relief for atypical situations. The forms to request an exception are easily attainable and understood. The exception review process is an opportunity to analyze the system when substantiating information is being reviewed, for example, facilitating a closer look at the structured interview process. This creates an opportunity for the exception review process to be incorporated into an evaluative, continuous performance-improvement process. HMA recommends that a clear plan for this be developed—or shared, if this has already been developed—including how and by whom this information will be reviewed. Such an approach can enhance transparency and perhaps address risks and weaknesses referenced previously.
- There is an opportunity to monitor and evaluate the effectiveness of stop-loss limits managing the transition to a significant individual budget reduction. This provision could be an opportunity to study the changes in the individual budgets and learn lessons for subsequent waiver program policy changes.

THREATS/RISKS:

After a careful assessment of the proposed approach, HMA identified risks with the proposed model, aspects of the approach that may pose challenges to the individual budget authorization system. Some of the threats in this proposed model involve re-basing, timing, workforce impact, waiver assurances (especially health and safety) and home and community based infrastructure.

- The stop-gain provision seems to suggest that if a person is determined to require more than their budget amount in the past, they will not be allowed to go over the defined threshold regardless of assessed need. This stop-gain limit may result in federal waiver compliance issues and may have the unintended consequence of jeopardizing how other waiver budgets are calculated.
- The model proposes to re-base on an annual basis from each available prior year's expenditures. As noted in the discussion of weaknesses, this approach is also a risk since the member's budget is so highly weighted on the amount the individual spent on services in the past. This could lead to two predictable threats:
  - a spiraling reduction in individual budget resources based upon factors other than individual need, which would ultimately lead to budgets insufficient to meet individual needs, and/or
  - an unintended consequence of incentivizing individuals, family caregivers, and providers to fully expend authorized budgets each year, causing an inflation of costs. This latter threat

bears special consideration because individuals and providers may believe the new model could equate to a "use it or lose it" methodology, which provides an incentive to reduce future risk by maximizing expenditures whether the services are needed or not.

- The proposed approach poses a risk of a downward spiral of reimbursement after the first year and subsequent years for people who do not qualify for stop loss/gain provisions, which may have an unintended impact on member health and safety. It will be difficult to meet the HCBS waiver assurance for health and safety if there is not a solid way to predict if institutionalization is due to functional deficits that cannot be addressed in HCBS or due to insufficient funding. It is not at all clear from the information reviewed whether the individual budgets are to be based only on a full 12-month period. The accuracy of the methodology is not clear for people who join the program, change living settings, or have many significant life changes that cause them to have wide swings in the spending pattern for waiver services. HMA recommends clarification of the process for individuals who may not be consecutively served without interruption for a twelve-month period, and those that have significant changes in their status during the base period.
- The new model excluded expenditures of "outlier" members—those members whose expenditures were in the lowest 10% or the highest 10% category. Populations that are extremely expensive (or inexpensive) will not be included in the baseline. Experience from other states makes clear that nearly all standardized assessment approaches applied to individual budgets suffer from an "Outlier Problem." Assessment instruments are normed and not therefore designed to handle outliers. Standard practice among states is to exclude outliers and address such individuals apart from regular rate-setting/funding allocation processes."[5] What is not clear in the new methodology is how these outliers will be handled in the individual budgeting process if they are not included in the baseline calculation. This is problematic for the IDD population where many people with similar behavioral challenges may live together in a congregate setting or when a significant number of individuals' expenditures have reduced the overall amount.
    - This nuance may be problematic for specialty providers or for members with diagnosis of autism (ASD). For example, if a provider serves only members with autism, and a significant number of individuals with autism exhibit challenging behaviors, chances are that the expenditures for the majority of this provider's members fall into the 10% outlier costs category. Because the individual budgets were set excluding costs that were spent to purchase behavior intervention, members living in such a setting, while they will receive an add-on for behaviors to their individual budgets, may not receive consideration for the cost of the behavior intervention. This imbalance seems to indicate that the model may not be representative of the population being served and not be adequate to meet the needs of members living in a setting that routinely provides behavioral intervention.
- There is a threat to the model because the functional assessment tool is not designed to be a cost allocation tool. Although the ICAP is a recognized functional needs assessment used for service planning, it is clearly not an acuity measurement for cost estimation. According to federal experts, some states are either moving away from using the ICAP or more selectively using the ICAP as a

component of rate determination, such as establishing tiers that individual budgets fall within.[6] Many states have developed their own hybrid assessments and have, with the assistance of their stakeholders, piloted and tested their assessments to prove their validity.

- Using 2016 expenditures for waiver services may create unintended risk to HCBS waiver compliance. Concern was voiced by stakeholders about the 2016 base year being atypical because it was directly after policy revisions and limitations on the amount of services were put in place. Using 2016 expenditures may result in members that cannot be safe in a HCBS environment at the new budgeted amounts. If the spending is not reflective of accurate, individual person-centered planning, includes incorrect assessment information, or is not typical or average because of mitigating circumstances, the state may find itself in a negative compliance situation with CMMS.

C. Other States' experiences

Other states have moved away from the use of ICAP for budgeting or cost allocation purposes. In fact, many no longer even use the ICAP for its intended purpose of care and service planning. Unfortunately, assessment instruments that are designed for both planning *and* budgeting purposes are few. According to the MACPAC Inventory of the State's Functional Assessment Tools for Long Term Services and Supports, 2015, very few states link the assessment tool to LTSS payment rates. Ten states are using the ICAP to assess individuals with IDD. Of the 10 states, 1 (Massachusetts) responded that the ICAP results are not linked to payment rates, 4 (Wyoming, Utah, Nebraska and Louisiana) responded that the results are linked to payment rates, and 5 did not indicate whether the results are linked to payment rates.[7] This same document indicates that many states have built upon basic assessment tools and have tested and piloted their own hybrid tools. Some states do not allow individualized budgets unless the member engages in participant-direction care options, and they put an overall cap on the waiver services across the entire enrolled population rather than individual caps. Individual service planning then is conducted according to individual needs assessment.

Currently, the state of Oregon is facing litigation over their home care services. In Oregon, last year, the Medicaid agency implemented across-the-board reductions to in-home care services, eliminating hundreds of hours of critical supports. A class action lawsuit was filed by Disability Rights Oregon on behalf of clients with IDD, arguing that benefit cuts conflict with a fundamental principle of the Americans with Disabilities Act: people with disabilities who can live in the community should not be not unnecessarily isolated.[8] In this lawsuit, the plaintiffs are seeking restorations of previous hours, *changes*

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[6] http://dhss.delaware.gov/ddds/files/DirectSupportRateRebasingReport_OMB-CGO_012314.pdf

[7] MACPAC Inventory of the state's functional assessment tools for Long Term Services and Supports, 2015 https://www.macpac.gov/publication/inventory-of-the-state-functional-assessment-tools-for-long-term-services-and-supports/

[8] Oregon, Temporary Freeze to Home Care Cuts, June 2017; https://droregon.org/odds/

to the assessment tool, notices of change in benefits, and more meaningful and transparent appeals processes. To date all changes are temporarily frozen.

D. Potential Impact

HMA was not able to find publicly available information about the new model (other than the provider presentation/PowerPoint) that articulates the potential impact of the proposed new model. The success of any new or revised policy and procedures for HCBS waiver participants and their families is heavily dependent on the ready availability of information about the new approach. This information should include, but not be limited to, the potential impact of the new model on participants and their families, on existing and future providers, on persons providing service coordination, and on existing or future state or contracted administrative procedures. The court document emphasized the importance of making the policy changes easy for members to understand and providing assurances that members could request exception review and explaining how to do so[9]. The PowerPoint presentation did not include information on the new model's relevance to the overall state budget, the Medicaid budget, any waiver amendments, interactions with CMS, or interactions with providers or other stakeholders. There was no mention of any committees or workgroups or collaborative efforts with interested entities to review and develop the new method. Any new policy, process, and procedure—especially those directly related to individual budget levels and authorizations—has the potential to impact members and their families, the provider industry, and the administrative and service entities that play a vital role in members' lives. As noted in the opportunities identified discussion, the proposed model offers improved transparency, but this is dependent upon the information being made broadly and readily available. HMA recommends development of a clear strategy to actively engage stakeholders in understanding the new process to promote trust and enhance communication.

E. Potential Monetary Impact

The proposed model is designed to be budget neutral. The purpose of the stop loss/gain provision is to assure members that they will not be harmed but also to ensure that the state budget is not adversely impacted. A missing component, however, is how much the state budget is spending for institutional services and the impact over time to the waiver application (Appendix J) and to cost neutrality. Under 1915 c HCBS waivers, states must ensure that waiver costs are less than or equal to the cost of the institutional programs for the same population enrolled in a HCBS waiver.[10] This requirement is taken from 1915(c)(2)(D) of the SSA. Appendix J of the Waiver Application addresses the cost neutrality requirement. The proposed policy change does not provide information about the other waiver programs or any indication that other waiver programs had been used for reference purposes or will be used in the future for comparison or evaluation purposes. More concerning is the impact to the overall Medicaid budget because there was not sufficient information about the amount of state plan services being used by this waiver population. West Virginia has personal care as a benefit on the state plan. It is

[9] Court document "Exhibit 1; Service Authorization System: case 2:15-cv-09655; Document 155-1; Filed 05/12/17; Page 1 of 30 Page ID#:2172

[10] CMS Medicaid Waiver application can be found at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/hcbs-waivers-application.pdf

not discernable if the cost of state plan services were considered in the calculations or if this was limited to just waiver service spending.

IV. Conclusion:

Although the new model being proposed addresses the complaints raised in the class action lawsuit, there are several components of the new model that raise questions about the sustainability of the waiver program over the long term. The SWOT analysis identified more potential weaknesses than strengths, as well as significant questions that should be further explored. Given these questions and concerns, it would be optimal to pilot this new system before determining the appropriateness of full implementation statewide. Field testing the new model with a representative sample of providers would provide a basis for testing, evaluation and validation of the new model. Testing and evaluation conducted with the engagement of key stakeholders would also open the door for improved communication and greater transparency with members and stakeholders. This would also allow for testing of minor changes to the administrative processes necessary for successful goal achievement.