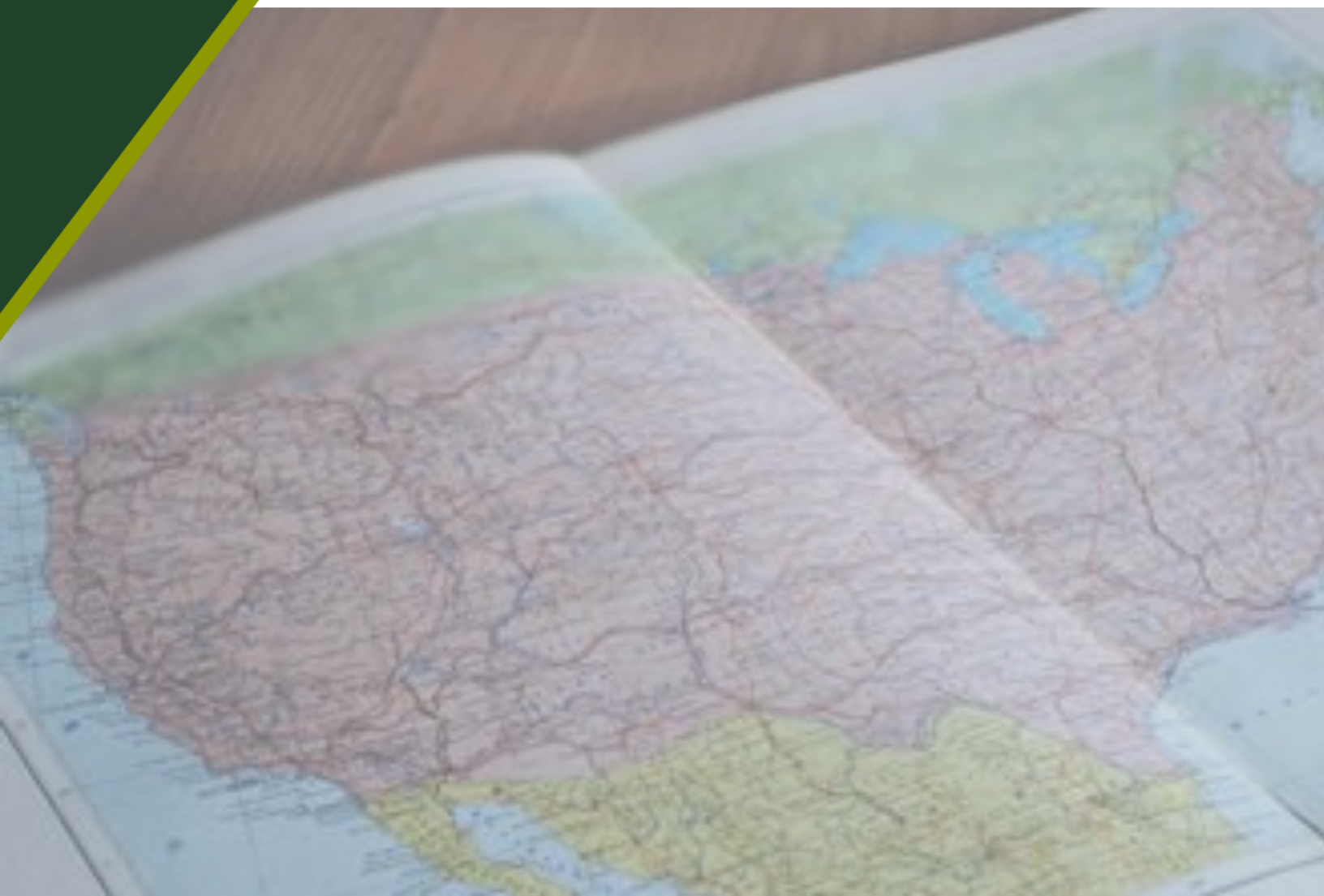
Analysis of Budget Methodologies & Research Into Other State Activities

Minnesota Waiver Reimagine Project

Study 2, Tasks 2.1 and 2.2



Prepared for:

Minnesota Department of Human Services
Disability Services Division
PO Box 64967
St. Paul, MN 55164-0967
https://mn.gov/dhs/

Prepared by:

Jami Petner-Arrey, Colleen Kidney, Yoshi Kardell & John Agosta
Human Services Research Institute
7690 SW Mohawk St.
Tualatin, OR 97062
503-924-3783
www.hsri.org

This project is sponsored by the Minnesota Department of Human Services, Disability Services Division (DHS/DSD). All opinions expressed herein are solely those of the authors and do not reflect the position or policy of the Department of Human Services.

April 16, 2018

About the Human Services Research Institute

The Human Services Research Institute (www.hsri.org) is a nonprofit, mission-driven organization that works with government agencies and others to improve health and human services and systems, enhance the quality of data to guide policy, and engage stakeholders to effect meaningful systems change.

Contents

INTRODUCTION

Background

HSRI is under contract with the Minnesota Department of Human Services, Disability Services Division (DSD) to complete two studies. The first will determine potential options for reconfiguring four Medicaid Home and Community Based Services (HCBS) waivers associated with people with disabilities. The second will determine a unified individual budgeting model for the proposed reconfiguration, both for individuals utilizing regular waiver services and those self-directing services through the Consumer-Directed Community Supports (CDCS) service.

Regarding Study 2, in advance of deciding on an individual budget methodology, the project team is undertaking a series of research and analysis tasks to gain knowledge of efforts elsewhere to establish individual budgets. The team is also undertaking an analysis of the MnCHOICES assessment tool and data collected to date, historical service use and costs, and the current CDCS methodology.

This paper pertains in particular to Study 2, Tasks 2.1 and 2.2, including results of research into both Minnesota's CDCS budget methodology and individual budget methodologies used elsewhere. What follows below are findings and analysis regarding this research, considerations, and description of the methods used to complete this work.

FINDINGS

Review of CDCS Budget Methodology

DHS has been on a path to develop an individual budget methodology for a number of years. This began with the advent of the CDCS budget methodology in 2003 (Minnesota Department of Human Services [DHS] MR/RC CDCS Budget Methodology Workgroup, 2005). CDCS, which became available statewide beginning in 2005, can be accessed from each of the four waivers considered in this project:

- Brain Injury (BI) Waiver: For people under the age of 65 years with a traumatic or acquired brain injury who need the level of care provided in a nursing facility or neurobehavioral hospital
- Community Alternative Care (CAC) Waiver: For people under the age of 65 years who are chronically ill or medically fragile and need the level of care provided at a hospital
- Community Access for Disability Inclusion (CADI) Waiver: For people under the age of 65 years who need the level of care provided in a nursing facility
- Developmental Disabilities (DD) Waiver: For people with developmental disabilities or a related condition who need the level of care provided at an intermediate care facility for people with developmental disabilities (ICF/DD)

CDCS uses a methodology that is tied to two "legacy" assessments, the Long-Term Care (LTC) Screening Document and the Developmental Disability (DD) Screening Document.

- The LTC screening document gathers a wide range of data on service recipients, including base demographics, personal history, general functioning, screening and assessment results, professional conclusions, Waiver/Alternative Care eligibility, service plan summary, alternative care needs and essential community supports information, and notes (Minnesota DHS, 2018a).
- The DD screening document covers case information, individuals present at screening, assessment section, informed choice, and notes (Minnesota DHS, 2014).

Both assessments are used to establish eligibility and, for individuals who elect to use the CDCS option, a budget limit based on a "case mix" classification. Eventually, both assessments will be replaced by the MnCHOICES assessment.

CDCS budgets are determined based on documented formulae. The approach was developed by selecting variables from each of the two assessments and regressing these variables against cost per day.[1] Variables that best predicted cost were chosen for inclusion. This formula is different for individuals on the BI, CAC, and CADI (combined referred to as CCB) waivers than for individuals who are served on the DD waiver. The variables used between the different waivers also differ, particularly for Mental Health. For the CCB waivers there are 13 case mixes: A-L and V (see Figure 1).

Figure 1

Case Mix Classification Summary

Classification
A—Low ADL
B—Low ADL Behavior
C—Low ADL Special Nursing
D—Medium ADL
E—Medium ADL Behavior
F—Medium ADL Special Nursing
G—High ADL
H—High ADL Behavior
I—Very high ADL (Eating 3-4)
J—High AL, Severe Neurological Impairment/3+Behavior
K—High ADL Special Nursing
L—Very Low ADL/Age 65+
V—Ventilator Dependent

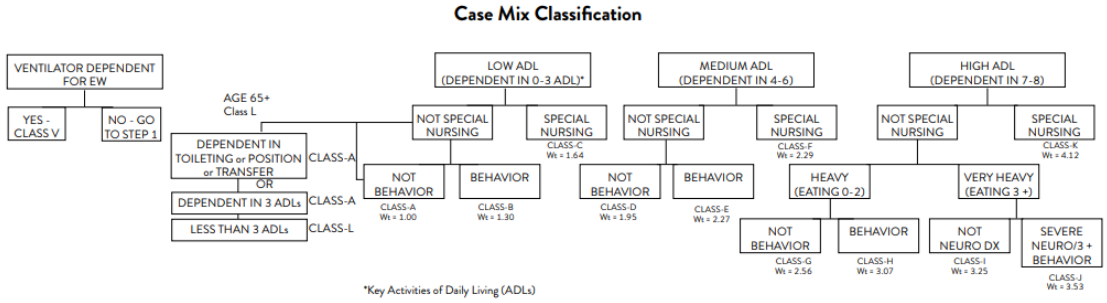
Adapted from: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428B-ENG

To arrive at a case mix classification, a series of steps are applied (Minnesota DHS, 2018b). The first step considers whether an individual uses a ventilator and scores from eight Activities of Daily Living (ADLs). Using responses to these eight items, an ADL category is applied. Using special nursing items from the LTC screening tool, an individual is assigned a special nursing case mix, if applicable. If not applicable, behavioral scores from the LTC assessment are used to assign an individual a behavioral classification upon meeting a threshold. If no nursing or behavioral classification is applied, dependencies in bathing, dressing, grooming, walking, and eating are considered. If the score on eating meets a threshold, certain neuromuscular diagnoses are also factored in. After all the considerations are applied, a case mix can be assigned. See Figure 2 for a schedule.

[1] Information on CDCS, if not otherwise referenced, is from personal communication via project meeting on January 24, 2018 with staff from Minnesota DHS.

Figure 2

CCB Case Mix Classification Schedule



https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428B-ENG

Once the case mix is established, a daily rate is calculated (Minnesota DHS, 2017c). The daily rate is calculated by using the case mix weight to multiply by the score received for that variable. The values are then added to the constant 15.218 to create the total daily weight. To calculate the total daily rate, 2.9 is subtracted from the total daily weight—and the resulting figure is multiplied by 0.70. The subtraction of 2.9 assured budget neutrality while the multiplication of 0.70 keeps the Lead Agency within budget. The resulting daily rate is adjusted for current cost of living adjustments (COLAs), rounded, and multiplied by 365 to derive the total annual budget.

The process is similar for the DD waiver, though the case mixes are established differently. A total daily weight is determined and then multiplied by 0.9964, a factor to show a one percent reduction imposed by the legislature in 2003, and finally multiplied by 0.70, a factor to keep lead agencies within their budgets (Minnesota DHS, 2017a). Like the CCB process, there are a series of steps used to derive the final case mix (Minnesota DHS, 2017a). To determine the daily weight, individual scores on selected variables are multiplied by an assigned weight. All of the values are then added with the constant -120.534 to create the total daily weight. Next the total daily weight is multiplied by 0.9664, then by 0.70, producing the total daily rate. After that the rate is adjusted for current COLAs, rounded, and multiplied by 365 to derive the total annual budget.

Among all waivers, CDCS budgets can be used for four categories of services:

- Environmental modifications and provisions
- Personal assistance
- Self-direction support activities
- Treatment and training

(Minnesota DHS, 2017b). Budgets can also purchase traditional goods and services (Minnesota DHS, 2017b). In CDCS, service recipients are informed of their budget and participate in the development of a Community Support Plan. Considering their available budget and needed services, the recipient is able to establish rates for the

individuals providing services, subject to approval by the county case manager, tribal entity, or health plan representative who reviews the plan to ensure that costs are reasonable and customary (Minnesota DHS, 2017b). Minnesota legislation has defined several established exceptions to allow for additional funding in certain circumstances for service recipients using CDCS budgets.

Review of Other Methodologies

We reviewed waivers and other sources to find information about methodologies used in other states. We completed additional research from each selected waiver to get additional information and to categorize the methodology. We chose example states to provide additional context and interviewed key informants in nearly all these states. We categorized each methodology and considered the strengths and weaknesses of each methodology. See the "Methods" section of this report for additional details.

Of 261 Medicaid waivers, we identified 43 waivers in 31 states that applied a methodology that resulted in an assessment informed prospective budget. We chose this criteria in an effort to identify only those methodologies that prove most useful to DHS's current trajectory.

Central to these criteria is the use of standardized assessments to inform the approach. Several states used a locally developed tool like Minnesota's MnCHOICES (e.g., the MONA in Montana, the QSI in Florida, the NJCAT in New Jersey). Other states used nationally recognized instruments like the Inventory for Client and Agency Planning (ICAP) or the Supports Intensity Scale (SIS).

A standardized assessment is used and is directly linked to the resulting budgets. The budget is known before the plan to estimate needed services over the coming year and is *not* developed by tallying services.

In each of the 43 selected methodologies, the assessment was key to the budget—that is the assessment meaningfully impacted the resulting budget amount. Typically, core assessments are combined with other variables to produce a budget. As result, the budget can be known prior to support planning and might be used as an estimate to guide service planning for the coming plan year. In each of the 43 selected methodologies, the budget was *not* arrived at by selecting needed services, adding units together, and multiplying by cost.

In our initial proposal, we outlined three approaches that we knew states to be using.

- An **Item-Based Approach** involves selecting items with a measure and associating responses to these items with a unit of support (e.g., hours or dollars). The units of support are then added to yield a total amount of support or budget.

- A **Level-Based Approach** uses analysis to separate individuals into a reasonable number of "assessment" levels where there is meaningful separation between the levels. Typically, these levels depict low to high support needs, with other categories becoming apparent that are related to complex behavioral or medical needs.
- With a **Formula-Based Approach**, the support needs of individuals are systematically analyzed in relation to costs (and perhaps direct service hours). Items in the assessment tool are examined to determine what combinations of independent variables can best explain variance associated with dependent variables (e.g., annual costs and/or a measure of services hours). The analysis yields a formula that assigns each person a budget amount.

In the beginning of our review, it seemed that many states conformed to one of the above approaches. After engaging in key informant interviews, however, it became clear that additional information outside of what was publicly available was needed to appropriately categorize each of the approaches within one of the above defined categories. Moreover, the methodology applied might utilize combinations of the approaches we originally described.

An individual methodology results in each individual having a unique budget.

A level methodology results in a group of individuals sharing a budget amount.

As a result, we reconstituted our categorization of the different approaches, dividing the methods into two primary categories: individual and level methodologies.

- An *individual methodology* is one that results in each person having a unique and distinct budget. For this budget to be applied, circumstances attributed to the individuals (e.g., specific needs indicated on an assessment, their previous year's budget) are required to calculate the budget, so that everyone may have their own budget. For instance, if a state serves 20,000 people in its waiver, theoretically there could be 20,000 unique budgets.
- A *level methodology* is one where groups are established whereby each group is defined according to common features of their need derived from the assessment and other selected variables (e.g., age and living setting). Generally, all individuals falling within a level are assigned the same budget allocation (unless finer distinctions are made within levels, such as by creating sub-levels). For example, the state may choose to assign service recipients to one of three levels based on needs identified in an assessment. They may choose to further break out the levels based on whether an individual is a child or adult since there are meaningful differences in need and cost associated

with these groupings. As a result, the state could establish a three by two matrix to display the six budgets an individual could be assigned.

Categorizing the findings by these two primary approaches provides an important distinction as each approach is designed uniquely and entails different obstacles and opportunities. In the findings that follow, we apply this distinction to characterize the type of budget allocation that a particular waiver finally employs. Note, however, that in building a budget allocation, individual or level, similar analyses might be used to produce either type.

Overall, the approach most commonly used based on these findings was a level methodology. This approach was used in 74% of the methodologies that met our criteria. Individual approaches were used in 11 or 26% of the methodologies. See Figure 3 for overall findings and Appendix A for more details.

Figure: 3

Level methodologies are the most common, used by three-quarters of the waivers we investigated.

WAIVER by STATE	INDIVIDUAL	LEVEL
AR Alternative Community Services		●
CO Supported Living Services		●
CT Employment and Day Supports		●
CT HCBS Community Supports for Persons with Autism		●
CT Individual and Family Support		●
CT Comp Supports		●
FL DD Individual Budgeting	●	
GA New Options Waiver		●
ID Developmental Disabilities Waiver	●	
ID Children's DD waiver		●
ID Act Early Waiver		●
IL Elderly Waiver		●
IN Community Integration and Habilitation		●
IA HCBS Intellectual Disabilities		●
LA Community Choices	●	
LA Residential Options Waiver		●
ME HCBS for Member with Brain Injury	●	
MS Intellectual Disabilities		●
NE Comprehensive DD Waiver for Adults	●	
NE Comprehensive DD Services	●	
NE DD Day Services Waiver for Adults	●	
NJ Community Care Waiver		●
NM Medically Fragile		●
NY Long Term Home Health Care Program		●
NC Innovations Waiver		●

WAIVER by STATE	INDIVIDUAL	LEVEL
NC 2008 CAP/DA		●
ND Medicaid Waiver for HCBS	●	
OH Transitions DD		●
OH Transitions II Aging Carve Out		●
OH Individual Options		●
OR K-Plan	●	
UT Physical Disabilities	●	
VA Building Independence Waiver		●
VA Family and Individual Waiver		●
VA Community Living Waiver		●
WA Individual and Family Support		●
WA Basic Plus Waiver	●	
WA Core Waiver		●
WV Intellectual and Developmental Disabilities		
WI Elderly and Physically Disabled		●
WI Self-Directed Support DD		●
WY Comprehensive		●
WY Acquired Brain Injury		●
WV		●

On the following pages, we provide additional descriptions of each methodology as well as examples to describe its use in three different states; Oregon, Idaho, and Virginia.

Individual Methodologies

An individual methodology is one that results in each individual having a budget that is unique to them. The means to develop an individual budget model in some cases are like those that are used to develop a level model. For example, either methodology can be determined using regression on historical costs. In an individual model this might be applied to develop weights for specific items that are then factored into an equation to determine the individual budget amount, like the current CDCS methodology. In a level model, regression might be used to determine current budget levels based on the previous year's costs, but once these costs are established a fixed amount of funding is provided, so that the budget amounts are finite and known.

The individual methodologies that we reviewed were developed using several approaches. Some of the approaches align well with those that we outlined in our initial proposal and described above. One way to develop this methodology is to use statistics to determine relationships between assessed need, other budget-impacting factors, and historical costs. This approach seemingly always involves regression or other statistical modeling using analyses to determine whether, and the extent to which, variables predict budget. After the statistical analysis is complete, a formula is developed that is then applied to each individual to determine their unique budget (e.g., Florida's approach described below). This formula always accounts for items in the assessment (e.g., through weighing of select items) but often also uses other variables. Some methodologies include the previous year's budget as a variable to determine the final budget (e.g., Idaho's approach described below).

Another approach for developing an individual methodology is to use what we previously described as an item-based approach. In this approach items within a measure are selected and associated responses on the items correspond to a unit of support (e.g., hours or dollars). The units of support are then added to yield a total amount of support or budget. In this approach, an item may probe the amount of support

Benefits and Challenges

The primary **benefit** of an individual methodology is that it is **highly individualized and may demonstrate strong statistical soundness**.

Some of the **drawbacks** are that it:

- May be difficult to explain and understand
- May be less flexible for service recipients
- Is reliant on support need assessment with strong psychometric properties to justify precise distinctions in support need
- Requires recalibrations that can be disruptive
- Is reliant on past spending rather than future policy directives
- Limits budget control and authority

needed to dress. Depending on the response to the item (e.g., low, medium, or high), a unit of support (time or money) is tallied. This approach is repeated for each item included in the model. A final tally across all the selected items and responses yields the individual budget amount. The amount of support associated with each item and response might be set based on professional judgement and/or analysis of previous service use and expenditure patterns. Once the assessment is completed a final budget is computed (e.g., Oregon's approach described below).

Benefits and Risks

One benefit of using individual methodologies is that, when approached properly, a strong defensible model can result. Given valid, reliable, and accurate assessment results, the model can be developed with sound statistical procedures that are well regarded and lend weight to the developed approach. These approaches also can lessen the amount of subjectivity involved in other approaches.[2] Since the methodologies are often complex, assessors and service recipients may not be fully aware of exactly how responses on an assessment factor into the final budget, potentially limiting responses during assessment to overstate support need.

The primary benefit of this approach, however, stems from the fact that each individual has a unique budget calculated for them based specifically on the needs that they indicate. Of the waivers that favor such approaches, the individual nature of the methodology is often strongly emphasized as a primary benefit of the approach. The methodology is popular because it results in a unique and individual budget assigned to each service recipient.

As with any methodology, there are a number of drawbacks from using an individual methodology. The first being that the methodology may be regarded as a mysterious "black box" that is difficult to explain or understand. While the methodology for developing the model may be supported by logical and statistical rationale, the resulting model will not directly and simply explain the way in which budgets are assigned. This is often due to the nature of the formula that is applied to each individual service recipient. The formulas are often quite complex and require substantial explanation for someone to understand how they are computed. As a result, even though the methodology can be made publicly available in an effort to be transparent (although some are not), it can be difficult to explain to service recipients and their families since comprehension of complex statistical techniques is not widespread. Therefore, even the simplest formula or adapted budget calculator likely contains information that does not relate directly to the budget in a way that most individuals in the public sphere can understand.

---

[2] In addition to using our expertise to weigh the relative benefits and risks of various approaches, these sections are aided greatly by the key informant interviews that we held with state staff described in the methods section of this report.

Another drawback is that, because the formulas used to derive the individual budgets are often so specific, they limit the ability of the individual to flexibly make decisions about their needs. One example is when the previous year's budget factors into the current individual methodology. In this scenario an individual is infinitely tied to a budget amount they received in the past despite how their needs for support may have changed over time. Similarly, when the approach yields specific hours applied to specific services the individual can choose, it necessarily limits their ability to choose other services that might be better suited to their needs.

Since these methodologies are often developed with a restricted set of items from the assessment, another difficulty rests with the methodology relying so completely on only the specific support needs asked about in the items included. This reliance can pose problems when the item is not asked uniformly of every participant, if it lacks meaning to certain populations (e.g., wording in the question is not well translated in another language or comprehensible to certain cultural groups), or when it is not an area for which an individual requires high support levels. For this reason, methodologies that rely on restricted sets of items must be developed with assessments that have strong psychometric properties—that is, assessments that have demonstrated validity and that are frequently tested for reliability. Even so, since these approaches focus on only specific items, they often negate other items which might factor heavily into support needs for some individuals.

Since this methodology is most often reliant on historical costs as its anchor, it must be updated frequently to account for changes in cost and other factors. Since the approach requires recalibration, the entire methodology is altered each time the approach is recalibrated. The weighting of items may change, an additional item may be found to be statistically significant, a former item that was previously included may no longer be statistically significant, and the formula to determine the individual budget will be altered. Most importantly, though, changes may amount to dramatic impacts to individuals when the formula is altered. This is because the goal is to account for relationship to historical costs rather than focused primarily on individual needs.

In addition, historical costs have embedded within them influences from past policy and practice. As a result, budget allocations based in historical costs tend to use past service use patterns to determine future patterns—an approach that reinforces the past. This outcome may be inconsistent with forward looking policy goals to alter service use practices to match shifting ideals or expectations.

Finally, in most cases, changes in policy or practice cannot be easily amended to an individual approach. For example, if a rate for a service changes dramatically, the rate cannot just be added to the budget. Either the formula is altered for all individuals regardless of whether they use of the service or the changes must wait until the methodology is recalibrated (and historical costs have caught up). Since these approaches are enmeshed in costs, it is much more difficult to tease out what is based on individual need. If a state has a reduction in funding, the state is limited in determining how best to apply the reduction and will often apply the reduction across

the board, even though it might be meaningfully tied to a service or need. In short, individual approaches may limit a state's ability to manage its overall budget strategically to ensure that each person is able to meet their needs through systemic changes.

State Examples

We used the state examples below to provide additional context for how each methodology was established, how it is currently used, and to provide other relevant details about the approach and methodology. Below we provide examples for Oregon, Idaho, and Florida.

Example: Oregon K-Plan[3]

The Office of Developmental Disability Services (ODDS) within the Oregon Department of Human Service serves approximately 14,000 adults and children living on their own or with their families, and the number served in these settings has been steadily growing in recent years (Institute on Community Integration [ICI], 2016a). Oregon uses what we refer to as an item-based model for individuals living at home and with their families.

Beginning in 2011, with the passage of the Affordable Care Act, Community First Choice Plans became allowable under Section 1915(k) of the Social Security Act. Oregon was an earlier adopter and developed its plan in July of 2013 (NORC at the University of Chicago, 2014). This model was developed in an effort to align funding mechanisms for individuals with disabilities to those of other groups covered under the new K-Plan. The Seniors and People with Disabilities Program[4] had set a precedent for using an item-based model.

In this approach, Oregon uses two assessments: the Adult Needs Assessment (ANA) and Children's Needs Assessment (CNA). Both assessments cover similar information pertaining to demographics, need for support in activities of daily living (ADLs) and medical/nursing needs, as well as other exceptional needs (Oregon Department of Human Services [DHS], n.d.a; DHS, n.d.b). State staff at ODDS used the assessment to determine different units of support associated with responses to different items (e.g., if someone requires a 2-person lift 6 times per day at approximately 10 minutes each, that equates to one hour of needed support per day) for each item on the assessment. To determine an individual budget, an assessor then inputs information and responses into the assessment which yields specific hour amounts of support. The hour amounts are tallied to compute allowable monthly service hours. See Figure 4 below demonstrating an example of how a single response on the assessment yields a budget. The first shows the response to an item in Ambulation/Mobility in the Home

---

3 HSRI is currently contracted with the state of Oregon to develop a framework to replace the approach detailed here.

4 Information on Oregon K-Plan, if not otherwise referenced, is from personal communication via phone call on March 30, 2018 with an individual from ODDS.

and Community, marked as needing a two-person assist. This singular response has amounted to a monthly hourly amount of 30.41 hours of support.

Figure 4

Need for two-person assist is directly linked to 30.41 hours per month of supports.

AMBULATION / MOBILITY IN THE HOME AND COMMUNITY	
	2:1 Review
	This section assesses the individual's physical ability to move around in the individual's home and community with or without mechanical aids. **Choose the option that most accurately reflects the supports required by the individual, which are not due to behaviors.**
○	**Independent:** The individual can move about in familiar surroundings without assistance from another individual with or without mechanical aids.
○	**Partial Assist:** The individual is dependent on assistance from another person for some aspect of ambulation/mobility.
○	**Full Assist:** The individual is dependent on assistance from another person for all aspects of ambulation/mobility.
◉	**Two-Person Assist**: The individual requires assistance of two people for all aspects of ambulation/mobility. ***Documentation required.***

In Home Needs Summary - Adult				
Name of Individual		**Date of Birth**		
Date of Assessment		**Age**		
		Assessed Hours	**2:1 Review?**	
		Per Day	N/A	
ADL/IADL Hourly Supports		1.00	Yes	
Behavior Hourly Supports		-	No	
Medical & Safety Hourly Supports		-	No	
Nighttime Hourly Supports		-	No	
			No	
Daily Average Attendant Care Hours		1.00		
Monthly Attendant Care Hours		**30.41**		
		Assessed Hours for Plan Development	**Adjustments For 2:1**	**Total Assessed Hours for Plan Development**
Start Date for Services		**Total Approved Monthly Attendant/Relief Care hours**	**30.41**	

Budgets generated from this methodology can be used for in-home services including Attendant Care or Relief Care (Oregon DHS, 2016). If the funding is not adequate, service recipients can complete a request for funding review or exception to outline their support needs and estimates for needed services or costs above the budget.

Example: Idaho Developmental Disabilities Waiver[5]

Idaho Department of Health and Welfare (DHW) operates the developmental disabilities 1915 (c) waiver for individuals with intellectual and developmental disabilities and Autism. This waiver serves approximately 4,000 adults in a range of settings including those who use residential services and those who are living at home with their families (ICI, 2016b). The model described here is what we previously referred to as a formula-based model.

It was developed using data from the Scales for Independent Behavior-Revised (SIB-R) assessment, a normed instrument that is used nationally to measure adaptive and maladaptive behavior. DHW characteristics which also factor into the budget are captured on the Inventory for Individual Needs. Assessments are completed by a third-party vendor. This approach features an algorithm that was derived from a regression model using selected items from the SIB-R assessment to formulate a calculated budget amount.

The final model uses 10 variables pertaining to the individuals circumstances and 8 pulled from the assessment (Idaho Department of Health and Welfare [DHW], 2009). The model is a regression equation that calculates total annual plan amount. The constant in the model varies by "waiver" or "non-waiver" service recipients. The multipliers in the equation are weights assigned to each of the variables included in the final model. As typical with a regression equation, the score of each variable is multiplied by its associated weight, summed, and added to the constant to calculate a budget amount. See Figure 5 for the equation.

[5] HSRI is currently contracted with the state of Idaho to develop a framework to replace the approach detailed here.

Figure 5

The regression model equation is:

$Y = b_1*x_1 + b_2*x_2 + b_3*x_3 + b_4*x_4 + b_5*x_5 + b_6*x_6 + b_7*x_7 + b_8*x_8 + b_8*x_8 + b_{10}*x_{10} + b_{11}*x_{11} + b_{12}*x_{12}$

Where:

Y = CALCULATED PLAN AMOUNT (ANNUAL)	MODEL COEFFICIENT WAIVER	MODEL COEFFICIENT NONWAIVER
x_1 = Waiver Status	25,628.54	6,211.20
x_2 = General Maladaptive Index (GMI*var)	-148.68	-57.16
x_3 = Mental Retardation	5,879.85	0
x_4 = Autism	4,389.63	0
x_5 = Cerebral Palsy	5,573.41	0
x_6 = TBI	2,672.81	0
x_7 = High Risk Behavior	2,139.01	0
x_8 = Nursing		
Nursing monthly	39,855.20	0
Nursing weekly/daily	61,204.97	0
x_9 = Level of Support Needed	908.68	0
x_{10} = Transportation	Imputed $	Imputed $
x_{11} = Sum of Bathing, Grooming, Dressing, Toileting, and Feeding (x*var)	167.26	458.47
x_{12} = Sum of Laundry, Housekeeping, and Meal Prep (x*var)	0	358.20

(DHW, 2009)

This approach was tested in 2009 (DHW, 2009). The additional testing found that the model worked well to predict the budgets and proposed several modifications. First, in the initial model, individuals were allowed to spend up to 5% more than their projected budget if their previous year's budget was higher than the current year's budget calculation (DHW, 2009). The proposed modification allows an individual to spend up to the previous year's budget if it is higher than the current year's budget calculation. Other proposed changes included adding living arrangement as a variable to be included in the regression formula and using a new calculated plan amount that includes an upper margin and lower margin (DHW, 2009). This report also recommended that a process be used to evaluate the needs of outliers, since the model could not account for all extenuating circumstances.

Service recipients who have budgets generated from this methodology use their budgets to pay for a range of services—from residential services to day services. If individuals need more funding, they can request an appeal of the budget from the Department's Administrative Procedures Division. The appeal must include documentation from a licensed professional to show proof that an area of the assessment was inaccurately assessed and include recommendations about specific additional support needed and the amount of funding required (DHW, n.d.). The waiver also includes a self-directed component and does not appear to have any differences in the budget methodology used to develop those services. For CMS approved funding description see Appendix B.

Example: Florida iBudget

The Florida Agenda for Persons with Disabilities (APD) serves approximately 30,600 individuals with ID, DD, and Autism on its 1915(c). The Florida Legislature mandated a new framework for determining budget allocations for waiver recipients in response to increasing need and concerns about the previous allocation system. The new framework is intended to enhance the simplicity, sustainability, and equity of the system while increasing individuals' opportunities for self-direction. The approach is also well documented, allowing for a detailed description.

Prior to adopting a new budget allocation framework, APD and its consultants determined the need to refine and test their support needs assessment at the time, the Florida Status Tracking Survey. In 2007-2008, the assessment was updated and adapted for the purposes of supports and budget planning. The new instrument, still used today, is called the Questionnaire for Situational Information, or the QSI (Agency for Persons with Disabilities, 2009). In addition to developing the assessment, APD contracted with the Florida Center for Inclusive Communities, UCEDD, at the University of South Florida to thoroughly test the psychometric properties of the assessment. They conducted a series of studies examining item analyses (Havercamp, 2009a), inter-interviewer reliability (Havercamp, 2009b), test-retest reliability (Havercamp, 2009c), and concurrent validity (Havercamp, 2009d). All studies provide support for good validity and reliability of the QSI. In addition to the initial studies of validity and reliability, APD conducts inter-interviewer reliability of all assessments to ensure the ongoing consistency of the SQI across their waiver population.

Since APD is confident in the validity and ongoing reliability of the QSI for indicating support need, they selected a formula-based individual budget methodology. The methodology generates an exact budget amount for each service recipient based on the recipient's living setting, age, and responses to items from the QSI. Niu and Bell (2010) developed the first generation of the algorithm, which APD began implementing in 2013. Niu and Bell used regression with transformations to create the budget methodology.

First, APD organized stakeholder feedback to determine what variables should be considered for the methodology. They found that stakeholders believed variables such as residential setting, age, mental health status, guardian relationship, and variables related to support need and functioning play an important role in budget. For example, individuals living at home with family have a different cost of living than individuals in group homes and foster homes. Therefore, their budgets should vary in a way that considers differences in living setting. The researchers and APD also decided that the framework should rely on historical cost to predict budget.

Niu and Bell then determined whether any of the variables required transformation to meet the assumptions of the regression analysis. That is, regression findings assume that all variables in the analysis align with a normal distribution. However, historical cost is heavily skewed; many service recipients use smaller amounts of money for

services than the mean cost. Therefore, the researchers applied a square root transformation to normalize the cost to meet the assumption of normality for regression.

They also prepared the dependent variable—cost—for use in analysis. They removed outliers, defined as extreme values for cost outside a 90% interval of the population—5% of the lowest and 5% of the highest costs outside the transformed normal cost. They restricted the analysis sample to only individuals with 12 months of claims and removed certain costs from the total historical spend. The analyses explored two fiscal years of claims data separately (FY 2006 – 2007 and FY 2007 – 2008) to ensure that model fitness is not restricted to a single, potentially unusual year.

Niu and Bell then tested a number of regression models to determine which variables should be included as predictors and which has the best model fit based on the Generalized Information Criterion (GIC) rule. GIC is an indicator of model fit used for model comparison. The GIC rule indicates that the best fit model is the model with the lowest GIC value. While multiple models adequately fit the data, the researchers found a best fit model which became the basis for the individual budget algorithm.

The model included age, living setting, and five summary and individual item scores from the QSI. The regression model provided weights associated with each of the variables. To calculate a person's individual budget with the algorithm, APD multiplies the score on each variable by the variable weight. Those values are then summed to create a total square root of predicted cost. The total is the square root due to the square root transformation of the historical cost that the researchers used for analysis. Therefore, APD squares that total to determine a final dollar amount.

The dollar amount produced by the algorithm served as a starting point for final budget determination in what is called the EZ iBudget Calculator. The APD then adjusts the amount to fit within the legislative appropriation, resulting in an Allocation Algorithm Amount. A Waiver Support Coordinator meets with each recipient to complete the Allocation Implementation Meeting Worksheet and assists with requesting Significant Additional Needs (SANs) if necessary. Finally, ADP reviews all materials and information and authorizes a final budget. The iBudget Notice confirms the iBudget Amount and approved waiver services.

APD began implementing this framework in 2013. Niu and Tao (2014) evaluated whether the framework fit to claims data in the first year of implementation. That is, they evaluated whether using the framework resulted in better prediction of historical cost than before APD implemented the framework. The evaluation showed that the FY2013 – 2014 claims data (implementation data) had a significantly higher R-squared value than the FY 2007 – 2008 claims data, indicating that the framework results in greater prediction of cost than prior to implementation.

While the evaluation supported use of the algorithm, it did not explore whether a refined algorithm may be a better fit. Niu and Tao (2015) sought to determine whether a better fit model exists and provide improvements to the algorithm. For this study, Niu and Tao essentially replicated the original methodology for model selection

with small improvements. They changed the fit criterion from the GIC to the Bayesian Information Criterion (BIC) to incorporate model complexity into the criterion. The SBC becomes larger with added complexity to avoid over-fitting a model. Therefore, the smallest SBC will be the best fitting and least complex model. Additionally, the methodology adjusted age groupings and residential setting categories based on updated analysis results and included all types of claims rather than excluding some as with the previous analyses.

Niu and Tao determined a new best fit model after testing a number of regression models. Just as with the best fit model from the initial algorithm analysis, the model is based on past expenditures and includes age, living setting, and items and scales from the QSI. The algorithm uses weights for each of the variables and calculates the initial budget determination. This model has an R-squared of 80%, which means 80% of the variance in historical cost can be accounted for by the variables included in the model.

The figure below displays the variables and weights included in the final iBudget algorithm, which APD implemented in 2017.

Figure 6

Independent Variables Used in the Final Model and Weights

VARIABLE NAME	DESCRIPTION	WEIGHTS
Intercept	Amount always added to model	27.5720
LiveiLSL	Independent Living and Supported Living	35.8220
LiveRHl	Residential Habilitation, Standard and Live In	90.6294
LiveRH2	Residential Habilitation, Behavior Focus	131.7576
LiveRH3	Residential Habilitation, Intensive Behavior	209.4558
LiveRH4	Residential Habilitation, CTEP and Special Medical Home Care	267.0995
Age21-30	Consumer age between 21 and 30	47.8473
Age31+	Consumer age 31 and older	48.9634
BSum	Behavioral status sum score	0.4954
FHFSum	Interaction term between Family Home and Functional status sum score	0.6349
SLFSum	Interaction term between ILSL and Functional status sum score	2.0529
SLBSum	Interaction term between ILSL and Behavioral status sum score	1.4501
Q16	Eating	2.4984
Q18	Transfers	5.8537
Q20	Hygiene	2.6772
Q21	Dressing	2.7878
Q23	Self-protection	6.3555
Q28	Inappropriate Sexual Behavior	2.2803
Q33	Injury to the Person Caused by Aggression toward Others or Properties	1.2233
Q34	Use of Mechanical Restraints or Protective Equipment for Maladaptive Behavior	2.1764
Q36	Use of Psychotropic Medications	2.6734
Q43	Treatment (Physician Prescribed)	1.9304

(Niu & Tao, 2015)

As described above, the output of the algorithm is just one consideration for a person's final iBudget amount. The final amount includes any appropriations and set-asides for exceptional needs, changed needs, and one-time needs.

Individuals can use their iBudget to pay for a range of services. The budget can only be changed if there is a dramatic change that prevents an individual from being able to meet critical health and safety needs. For CMS approved funding description see Appendix B.

Level Methodologies

A level methodology is one that involves individuals being grouped to be assigned a budget. This methodology uses several groups or categories to separate a service population based on defining attributes (e.g., assessed support need). Each level is associated with a budget allocation, so that each person assigned to a level is assigned the same budget. Usually, level methodologies are "two pronged," meaning that two distinct tasks are undertaken—one to define support needs and another to define the budget associated with each level.

To determine support needs, an analysis of assessments is usually completed. This analysis can be completed in myriad ways. For example, items on the assessment can be regressed on historical costs to determine add-on amounts to a base budget (e.g., West Virginia's approach described below). Alternatively, analysis can be completed on the assessment alone to decide on the number of levels, combine scores, combine domains, or inform score cutoffs. Often, but not always, levels range from low support need (and therefore smallest budget) to high support need (and therefore highest budget). Separate levels may also be established for certain extraordinary needs, such as elevated medical or behavioral needs.

To determine budgets for each level, another analysis is usually completed. This analysis can also produce levels. For instance, an analysis can be used to determine historical costs for different living settings to use as the base budget with increasing costs by living setting (e.g., West Virginia's approach below). Another approach for determining budgets is to review historical costs by established levels to determine a typical service use pattern. Aided by professional judgement and stakeholder review, use patterns can be defined into a service mix that outlines the explicit services included in the budget, the units and cost of which are multiplied to create the annual budget (e.g., North Carolina's

Benefits and Challenges

The **benefits** of a level-based approach include:

- More comprehendible
- More flexibility for service recipients
- Accounts for error in assessment and process by reducing specificity in budget
- Aspects may be recalibrated without disturbing entire methodology (if levels and budgets are separate)
- Aids in budget forecasting

Some of the **drawbacks** are that:

- Less individualized
- Sometimes still based on historical cost
- Sometimes requires additional data collection (besides assessment)

approach below). Another approach for defining costs is to create ranges using historical costs.

In this approach each analysis informs the budget methodology that is later applied—support needs and cost are added to compute the budget. All of the possible outcomes of the methodology are known, each individual budget can be placed in a matrix with level on one axis and budget on another.

Benefits and Risks

A benefit of this approach is that after the model is developed the framework can be easy to communicate with service recipients and other stakeholders. Since all possible budgets are known before an individual participates in an assessment, they can be succinctly displayed and explained. An individual might be able to see, for example, that if they live in a certain setting and have a certain score on their assessment, their level is going to be within a given range.

Level methodologies most often do not rely on specific items predicting historical costs, so that the assessment, as a whole, or items chosen by stakeholders can be used to determine the support level. Analysis can aid decisions about which items to choose, how many levels should be established, and what support need profiles look like. Since the methodology can be modeled on scores for an entire assessment rather than particular items, assessment error or misinterpretations about different items are less impactful to the individual service recipient. Since these approaches often involve ranges of funding for individual budgets, they allow for more flexibility for service recipients. Additionally, many of the approaches allow for individuals to mix and match the services that they choose with caveats in how much can be spent (e.g., limits on the number of units of a service that can be purchased).

Another benefit of level methodologies is that changes to the methodology can be applied with relative ease. If a rate increases for a service, the budgets for only individuals who use the particular service can be increased. Likewise, if the assessment is changed, the new items can be linked to the previously established support levels without altering the associated budgets. These approaches can also account for systemic changes. When new services are added to the existing service array they can also be added to the service mixes and their cost accounted for in the budget.

Finally, since the budgets are all known, and the levels can be understood as percentages of the total number of people served, data can be used to understand system changes overtime and to forecast how many people with different needs will be served over time. For instance, if 1,500 people are served in one living setting and are evenly divided among three support levels, the costs of which are known, a state would be able to predict the cost of adding 1,500 more people into those living settings, if needed.

The primary drawback of this approach is that it is less individualized. Since people are grouped into some sort of leveling system, and the methodology does not produce a unique budget for each service recipient, it may be seen as being less person-centered. For the approach to work, individuals must be made members of a particular group, which individuals may decide does not reflect the true level of their need.

Many of these approaches are rooted in historical costs. Regression of historical costs may be used to either form cost groups (e.g., a base budget based on living setting) or to determine specific items that contribute to support needs. Anchoring these methods in historical cost may limit a state's ability to change the status quo in the system.

Finally, level methodologies attempt to define support need distinct of defining cost. Since the approach often begins with a comprehensive vision about what support need holistically looks like, the approach works to find means to arrive at that support need. No assessment perfectly captures individual need, so there may be an obligation to collect additional data to ensure that individuals are placed in the appropriate level.

State Examples

We use state examples below to provide additional context for how each methodology was established, how it is currently used, and to provide other relevant details about the approach and methodology. Below we provide examples for West Virginia, North Carolina, and Wyoming.

Example: West Virginia Intellectual/Developmental Disability Waiver (IDDW)

The West Virginia Home and Community-Based Services IDDW serves approximately 4,600 individuals[6] (ICI, 2016c). The goal of the program is to provide person-centered services via traditional and self-directed options to individuals in the least restrictive manner in the community (West Virginia Bureau for Medical Services, 2018). The West Virginia Bureau for Medical Services (BMS) developed a new budget methodology and service authorization process for implementation in 2018. BMS identified several reasons for developing a new methodology, including that the old methodology was not transparent, was not easily understandable or explained, and was based on outdated claims data.

BMS sought to create a new methodology that was transparent and clear. The system includes clear and detailed forms and notices about budgets, including when individuals seek and receive dollars in excess of their calculated budget. Another goal of the BMS' new system was accuracy in the budget calculation. BMS contracted with third-party actuaries and researchers to develop the new methodology. Lastly, BMS

---

[6] Information on IDDW, if not otherwise referenced, is from personal communication via phone call on March 30, 2018 with an individual from the West Virginia Department of Health and Human Resources Home and Community-Based Services Unit.

sought to create a methodology so that each person's budget is based on their individual characteristics, including any necessary exceptions.

To create an individualized budget, BMS includes a measure of support need in the calculation. They selected the Inventory for Client and Agency Planning, or ICAP (Bruininks, Hill, Weatherman, & Woodcock, 1986), for measuring support need since the ICAP was already used in the state for planning purposes. The ICAP is well-documented in the literature as a valid and reliable instrument for planning and budgeting (Harries, 2008). The valid and reliable psychometric properties of the instrument provide the basis for an accurate methodology. BMS assesses each new service recipient with the ICAP and again annually.

BMS has not publicly released the details of the methodology development analyses. However, BMS publicly shares the overarching approach and the resulting methodology (Nisbet, 2017). BMS contracted with the Lewin Group to conduct regression analyses to determine the best model for an individualized budget methodology. The resulting methodology determines a base budget from three variables: age (under 18 or 18 and older), living setting, responses to the ICAP. Then, previous spending and a thorough exceptions process allows for an additional authorized amount.

First, BMS calculates the base budget, which is a dollar amount range with a low end and high end that varies by age group and living setting. Lewin Group determined these base budget amounts via regression of past spend on living setting and age. The figure below displays the base budget ranges for each category.

Figure 7

Base budget categories and ranges

CATEGORY	BASE BUDGET RANGE
Youth (below 18) living at home with family	$29,643 -- $33,081
Adult: living at home with family	$38,283 -- $44,231
Adult: intensively supported setting self-directed	$82,519 -- $94,830
Adult: waiver group home, 4 people	$78,540 -- $85,687
Adult: intensively supported setting, 3 people	$104,318 -- $110,027
Adult: intensively supported setting, 2 people	$123,279 -- $128,562
Adult: intensively supported setting, 1 person	$176,731 -- $182,507

(Nisbet, 2017)

Next, service coordinators review the most current ICAP and determine whether the service recipient needs additional funding for add-ons. The add-ons specifically relate to scores in four sections of the ICAP on motor skills, personal living, externalized problem behavior, and asocial problem behavior. The figure below displays the add-ons.

Figure 8

ICAP score ranges and associated member level with add-on dollar amount to add to base budget.

MOTOR SKILLS

SECTION/ITEM RAW SCORE	MEMBER LEVEL	ADD-ON AMOUNT
39 – 54	0	$0
33 – 38	1	$1,459
27 – 32	2	$2,918
15 – 26	3	$4,377
1 – 14	4	$5,836
39 – 54	0	$0
33 – 38	1	$1,459

PERSONAL LIVING SKILLS

SECTION/ITEM RAW SCORE	MEMBER LEVEL	ADD-ON AMOUNT
37 – 63	0	$0
30 – 36	1	$1,233
23 – 29	2	$2,466
12 – 22	3	$3,699
0 – 11	4	$4,932

EXTERNALIZED PROBLEM BEHAVIOR (ITEMS E2, E3, E4)

SECTION/ITEM RAW SCORE	MEMBER LEVEL	ADD-ON AMOUNT
Moderately serious or slightly serious	--	$2,968
Extremely serious or slightly serious	--	$4,287

ASOCIAL PROBLEM BEHAVIOR (ITEMS E6 & E8)

SECTION/ITEM RAW SCORE	MEMBER LEVEL	ADD-ON AMOUNT
Extremely serious or slightly serious	--	$3,840

(Nisbet, 2017)

For example, an adult living at home with family (base budget range = $38,283 to $44,231) has scores on the ICAP that qualifies her for member level 1 in both motor skills (Level 1 add-on amount = $1,459) and personal living skills (Level 1 add-on amount = $1,233) and no moderate or serious externalized problem behavior or asocial problem behavior. Her budget range is calculated as ($38,283 + $1,459 + $1,233) to ($44,231 + $1,459 + $1,233), or $40,975 to $46,923.

Next, BMS considers past spend to ease the transition into the new budget methodology. The “Stop-Loss/Stop-Gain” rule adds or subtracts from the new calculated budget to make the amount closer to the previous year. Specifically, the

Stop-Loss rule means that if a person's new budget is lower than their past year's spend, they will receive the higher of the budget assigned through the new budget system or 80% of their previous year's spend. The Stop-Gain rule means that if the person's new budget is higher than their last year's spend, they will receive the lower of the budget assigned through the new budget system or 120% of their previous year's spend.

BMS has an exceptions process that individuals may access if their new budget is not adequate for their needs. A group called the Interdisciplinary Team (IDT) and a panel of three qualified employees at BMS consider all exceptions and make every attempt to purchases services if deemed necessary.

Example: North Carolina Innovations Waiver[7]

The North Carolina Innovations Waiver servers approximately 13,000 children and adults with intellectual and developmental disabilities.[8] The objectives of the program are to enhance person-centered planning, allow services and supports with person-centered plans, promote smaller community congregate living situations, and for people to live and work in the most integrated settings (North Carolina Department of Health and Human Services [DHHS], n.d.). HSRI was retained by DHHS to develop the approach after having developed the budget methodology in use by the Piedmont Behavioral Health Managed Care Organization. HSRI remains under contract with the state in continued implementation of the model.

In response to Session Law 2011-264, which provided for a major restructuring of the management, financing, and delivery of services for individuals with IDD, DHHS developed a budgeting model based on the Supports Intensity Scale, along with other factors, and implemented it in 2016. In this model, resources are allocated to individuals based on their assessed level of need and associated level assignment (North Carolina DHHS, n.d.). The Supports Intensity Scale was selected because it is an internationally recognized assessment that measures the level of supports needed in a number of areas, including home living, community living, and health and safety supports, as well as exceptional medical and behavioral support needs (American Association for Intellectual and Developmental Disabilities [AAIDD], 2008). SIS assessors receive regular updated training and are expected to participate in inter-rater reliability testing on a regular basis (www.aaidd.org).

To develop the budgeting framework, DHHS, in consultation with HSRI and Burns & Associates, collected SIS assessment information on a representative sample of service recipients stratified by age, residential option, and managed care organization (MCO). Based on the assessment results (and verification outcomes if applicable), individuals were placed into one of seven levels determined by both cutoff scores for sections on the SIS and raw scores from sections for medical and behavioral needs.

---

7 HSRI worked with North Carolina to develop this methodology and is currently contracted with the state to assist with implementation.

8 Since many of the details of this approach are not publicly available, we discuss the approach, an approach that HSRI has used in several states in general terms.

The support level design is based on work begun by HSRI in 2006 in Oregon to regress SIS subscales to historical costs to determine which scales and scores best informed the budget methodology. The details of the methodology development analyses are not published; however, the overarching methodology and resulting framework are available. The level framework considers the subscale scores related to Home Living, Community Living, and Health and Safety, as well as the Medical and Behavioral sections. Four levels are related to general support needs, from low to high; one level is reserved for individuals with modest general support needs but elevated behavioral support needs; and two levels are reserved for individuals with extraordinary medical or behavioral needs. The levels are labeled A-G (NC Division of Medical Assistance [DMA], 2016).

The level framework is intended to be a best-fit model that will reflect the support needs of most individuals. However, to optimize the framework's sensitivity to extraordinary medical or behavioral challenges, four supplemental questions developed by HSRI are asked in addition to the SIS to identify those with the highest level of support needs. Certain responses to the supplemental questions that indicate that extraordinary medical or behavioral support may be required are reviewed by a verification committee that determines whether placement into a higher level is warranted. The verification committee's decision overrides the initial level assignment, so that the individual is placed into the behavioral level.

Service packages were developed through a process of reviewing historical cost service use by level and developing a typical use pattern. DHHS reviewed several model services packages and chose the service mixes that best fit system goals and the needs of individuals served. These service packages were validated to test their adequacy (DMA, 2016). Each individual is assigned a base budget and associated service package based on the assigned level, residential setting, and age (DMA, 2016). The North Carolina Innovations Waiver budgeting methodology was implemented in 2016. During initial implementation DHHS chose to phase individuals into the new budgets by reviewing the past year's budget and calculating it at a 120% or 110% for individuals who were over budget and 90% or 80% for individuals who were under budget. See Figure 9 for an example of how this budget might look.

Figure 9

Example Budget Table

SUPPORT LEVEL CATEGORY	ADULT RESIDENTIAL	CHILD RESIDENTIAL	ADULT NONRESIDENTIAL	CHILD NONRESIDENTIAL
A	$65,000	$60,000	$20,000	$7,000
B	$69,000	$62,000	$22,000	$9,000
C	$72,000	$67,000	$24,000	$11,000
D	$75,000	$72,000	$26,000	$13,000
E	$80,000	$75,000	$28,000	$15,000
F	$85,000	$85,000	$33,000	$20,000
G	$90,000	$90,000	$38,000	$25,000

The individual budget is intended only as a guideline for the amount of funding available to an individual, and service recipients are encouraged to request the services that they need irrespective of their budget (NC DMA, 2016) The service package covers only a number of base budget services. Base budget services are Community Networking Services, Day Supports, Community Living and Supports, Respite, and Supported Employment. Any additional services that are not part of an individual's service package are considered add-ons and treated separately NC DMA, 2016). There is a self-directed option, and the budget methodology and budgets are the same for individuals who elect to use that option. For CMS approved funding description see Appendix B.

Example: Wyoming Individual Budget Amount (IBA)

Wyoming Behavioral Health Division (BHD) uses a level-based model to assign a level of support need to each service recipient which is associated with a budget amount[9]. BHD serves approximately 2,200 individuals with IDD and/or traumatic brain injury (Larson, et al., 2018). The Wyoming Legislature passed Senate Enrolled Act 82 which requires BHD to optimize services provided to service recipients and reduce the waitlist by extending services to more individuals (State of Wyoming, 2013). The new framework, which applies to only adults receiving services, adopts individual budgets to address the Act. BHD began implementation of the framework in 2014.

For determining support need, BHD uses the Inventory for Client and Agency Planning (ICAP) to determine eligibility and assess support need. As we discuss in previous sections, the ICAP is a valid and reliable tool used widely for support planning and assessing support need (Harries, 2008). In addition to the ICAP, BHD includes age group (specifically, in school or out of school) and living situation.

BHD specifically designed the methodology to calculate level of service based on their description of each level, then create budgets for each level separate from the level methodology. So, while each level corresponds to a budget amount, the budget is not derived directly from the ICAP. BHD determined the appropriate budget for each level that they assign according to the level of service.

BHD developed the methodology for assigning the level of service and associated budget by first creating qualitative level descriptions or definitions. BHD first decided on a number of unique levels, six in total. They then crafted specific descriptions or profiles of support need for each of the six levels. The developed the descriptions with experts at BHD. These descriptions included what supports an individual in the level is expected to need.

Next, BHD created a dataset of 140 individuals' ICAP assessments (Wyoming Department of Health Behavioral Health Division, 2014). Forty percent of the dataset contained individuals with very high or very low support needs to ensure that the data

---

9 Information on IBA, if not otherwise referenced, is from personal communication via phone call on April 6, 2018 with individuals from Wyoming Behavioral Health Division.

represented the entire spectrum of needs. BHD randomly selecting the remaining 60% from the population of existing ICAP assessments of adults with IDD and acquired brain injury. In total, the 'calibration dataset' included 140 individuals.

BHD used the level definitions and ICAP assessments for a survey of 16 experts in-house and at WIND (Wyoming's UCEDD and ICAP contractor). The experts familiarized themselves with the level definitions, then looked at the ICAP results of each of the ICAP assessments that BHD randomly provided. Each expert reviewed 70 of the 140 individuals with ICAP data. For each individual with ICAP data, the expert assigned a level of service.

BHD created an average level score based on all of the levels that the experts assigned to a given individual in the calibration dataset. Using this average level, BHD regressed level of service on ICAP scores. They tested multiple models using the ICAP scores and other variables (e.g., age and living setting) in different ways to come up with a best fit model. From this best fit model, BHD selected the variables for inclusion in the level of service criteria. The final level of service model included the ICAP general score and personal living domain score, as well as behavioral scores derived from ICAP sections. BHD used the final regression models as the formulae for placing individuals into levels.

BHD describes the final methodology for level of service need as taking place in 3 "passes." In the first past, the ICAP "service score" – a final calculated sum of the ICAP—determines an individual's level (from 1 to 6). The formula for the first past is: Level = -0.0619 * service score + 6.827. The final level is rounded to the nearest tenth. While the level descriptions apply to only the discrete numbers, budgets are split down to levels with decimals. That is, if a level 1 budget for day habilitation is $10,000 and a level 2 budget is $20,000, a level of 1.5 results in an authorization of $15,000.

Then, a second pass calculates a new level (from 1 to 6) that considers medical and behavioral scores. If a medical need is required daily or needs 24-hour access, 0.125 is added to the level. If one or more of four serious behaviors is at least daily, very serious, and requires physical redirection or getting help, 0.125 is added to the level. As with the first pass, the level is rounded to the nearest tenth.

After the second pass, the levels calculated during the first and second passes are compared. BHD selects the higher of the two levels the level of service need. Lastly, a third pass considers other assessment information on the person that relate to high cost needs, as well as other information including former plans of care and service utilization. The third pass may modify the assigned budget or the level of service need as appropriate.

The final level of service need is then tied to a budget. The budget is based first on age group and residential setting. For individuals living with family, the budget is based on the hourly rate for personal care services multiplied by the estimated required hours of service for each level. BHD determined the estimated hours of service for each level based on exploring past utilization and determining the "typical" number of hours used by individuals in each level. For individuals living independently or semi-

independently, the budget is based on the daily supported living rate multiplied by the estimated days of service required by each level. The same methodology applies to day service budgets and residential habilitation.

BHD provides individuals with their level of service need and associated budget. If the individual or their Plan of Care team believes the budget is not adequate for the person's needs, a system is in place for reviewing and/or retaking the ICAP and/or filing an appeal. During the phasing-in of this new budget methodology, BHD incorporated a cap on budgets so that no one's current budget goes up or down more than 7%. For CMS approved funding description see Appendix B.

Key Informant Lessons

As described previously and outlined in more detail in the "Methods" section of this report, we had key informant interviews with state staff from nearly all the states profiled here. In these interviews, we heard many lessons of value to DHS. Below we describe these lessons in four areas: stakeholder communication, assessment, service recipients, and system.

Regarding Stakeholder Communication

In every interview, state staff relayed the importance of speaking with stakeholders to either include them in the development of the approach or to make sure that they understood critical aspects of the methodology. These show the importance of communicating about the methodology, making sure that service recipients understand the methodology, and being sure that the methodology makes sense.

Communicate early and often. In several of the interviews, state staff mentioned the importance of communicating with stakeholders as soon as possible about the potential approach. Several states included stakeholders in some way in the development of the approach. While there was a range of ways to include stakeholders, states stressed that stakeholders be made aware of the approach.

Choose an approach that can be made transparent and comprehensible. Any approach can be shared with stakeholders, but all approaches may not be comprehensive to individual service recipients. The ability to understand the budget has often been contested in legal proceedings since individuals need to understand how their budget was derived to be able to request additional funding, or to be able to file grievances or complaints if they feel the budget is insufficient. DSH should consider its own plans for publishing the methodology and being sure that it can be understood well enough by service recipients and individuals who support them.

Use a defensible methodology. Since individuals rely on this funding for their support, methodologies are often subject to intense scrutiny. As such, it is imperative that the methodology has sound statistical or other evidence to explain how the precise decisions were made. This includes everything from ensuring that the sample

(when samples are used) is representative, to ensuring that final methodology can be tested by independent parties.

Regarding the Assessment

In nearly all of the interviews state staff discussed the importance of the assessment and how it was perceived by service recipients. Overall, key informants discussed the importance of using valid and reliable assessments, making sure that account for all support needs, and giving consideration for how to deal with exceptional support needs.

Use an assessment that has integrity. Since the assessment will bear a significant burden in determining needs that will later be matched to dollar figures, the assessment will also be the subject of intense scrutiny. For these reasons, assessments must have strong psychometric properties—that is assessments must be valid and reliable. Further it is important that this reliability is checked on an ongoing basis.

Consider the specificity of the approach. If the approach is too reliant on single items (or only a handful of items) in an assessment they bear significant weight in being correctly captured (e.g., a single response has a meaningful impact on the budget). For this reason, the assessment will need to demonstrate sensitivity in adequately capturing the selected items. Additionally, no single assessment can capture every persons unique support needs, nor can. Limiting the specificity of an approach has the potential to present a fuller more holistic picture of the person's support needs.

Account for exceptional circumstances. If the assessment itself does not adequately measure exceptional medical, behavioral, and other needs, it may be necessary to add additional assessments and/or processes to the methodology to account for these needs.

Regarding Service Recipients

In each interview, key informants weighed the benefits of the methodology with the impacts to the system. Some of these informants mentioned that person-centeredness should be balanced with the ease of managing whatever changes were put into place. Key informants recognized the need for having easy to access and robust exceptions processes, smoothing over the transition into one methodology from another (or to a new one), and choosing the simplest possible method.

Balance person-centeredness with ease of administration. While person-centeredness is very important in the development of any budget methodology, it is also important to consider how easily any given methodology can be implemented. The methodology cannot be so complicated that it is difficult for the department to implement or to manage.

Establish means for exceptions. No approach can yield perfect results to match every individual to a budget amount. There will always be some number of people who will have needs that extend beyond the boundaries of what the methodology can capture. It is important to be prepared to deal with requests for additional funding by having a robust process in place that easily enables service recipients to request funding beyond their budgets, and that can be objectively evaluated.

Limit Transition Disruption. With the adoption or recalibration of a budget methodology transition is inescapable. While some changes, and therefore transitions are warranted (e.g., reducing funding for outdated services to bolster others), these transitions should be limited and cause the least disruption possible for individuals. To smooth service recipients over initially states often choose to phase the new budgets in over a period of time. Similar once the model is established, the least disruptive changes should be pursued.

Consider Simplicity of Methodology. Regardless of the approach chosen, the simplest methodology should be applied. Simplicity is important because it helps states to achieve a number of other goals such as communicating with stakeholders, easing implementation efforts, and contributing to the model's sustainability overtime.

Regarding the System

Just as key informants were concerned about the making sure that the methodology was person-centered, they were also aware of the system-wide impacts of adopting a budget model. The key takeaways in this regard are to choose a methodology that can be recalibrated with relative ease, that can provide the state with a fuller picture of the support needs in the system to allow for future planning, and that the methodology is reviewed by the Department's legal time consider any problems.

Adopt an approach that can be easily recalibrated. All approaches will need to be adjusted in some way overtime. They may need to be adjusted to account for enhanced service rates, new services, changes in the assessment instrument, or for other reasons. Developing an approach that can account for changes can help with methodology stability overtime.

Allow for future forecasting. Many states choose to pursue a budget methodology approach so that they can better predict future costs. One of the primary benefits of implementing a budget methodology is to be able to see the system through a framework or lens that can assist in decision-making and planning. The methodology chosen should give the state "eyes" on its system.

Consider legal and notice requirements. Several states discussed instances where the methodology or related elements were contested in court. This is particularly important when changes lead to budget reductions since individuals are likely to be dissatisfied or feel that their needs will not be met. Often when these complaints have risen to the level of legal action, the notice requirements have been

central to the complaint. It is important to consider how individuals will receive notice of their budgets and to ensure that the notice meets all legal requirements. This is but one piece of the puzzle, it is important to discuss both the approach and resulting methodology with legal counsel to look for areas that might cause problems and to begin thinking about processes or procedures that are needed or procedures that will need to be altered prior to implementation.

CONSIDERATIONS

Minnesota has been on an extended journey to develop an individual budget methodology. There are many elements that DHS has put into place that are conducive to the development of these budget. DHS has:

- Established **principles and intentions** that are consistent with person-centered principles;
- Expanded the **services available** to offer a broad range of access to individuals across the four waivers;
- Established a **rates framework** through the Disability Waiver Rate System (DWRS) for agency-provided service; and
- Now needs to consider an **individual budget methodology** that will best meet the needs of individuals served among the four waivers.

This review of research and the lessons learned from interviews about each approach will help to facilitate additional work to establish an individual budget methodology.

Next Steps

With this information in mind, Minnesota can begin to make decisions about the approach that will work best for Minnesotans with disabilities. The next steps necessary to facilitate such a decision will be to complete the following activities.

Review the MnCHOICES assessment to determine how it will factor into a budget methodology. This analysis will allow us to not only explore the psychometric properties of MnCHOICES, but also to identify trends in support need across waiver participants. Generate crosstabs regarding selected variables to help contextualize differences in the population by waiver type

These analyses will help us to understand how the level or magnitude of support need is distributed across the population, from low to high, and the relative presence of other relevant factors (e.g., significant medical complications, behavioral challenges). This analysis will also inform the service use and spending analysis.

Analyze service utilization and spending across the four identified waivers. This analysis will provide key insights into current service use patterns to inform the development of a budget methodology.

This analysis will help us to understand differences across waivers and by support need to consider how to best develop the budget.

Decide on individual budget approach with the Methodology Review Team (MRT). Once we have established a firm understanding of how the MnCHOICES tool is applied to individuals with disabilities, how it can be used to understand a range of

support needs, and how services and costs vary among individuals with a range of support needs, we can begin to decide how to approach the task of developing an individual budget methodology. We will work in close coordination with DHS to determine which approach is best.

We have presented a variety of methodologies, of which DHS may want to pick and pull from as it meets its needs. As DHS moves ahead, it will want to be careful to consider the many aspects that impact the individual budget methodology that it chooses. DHS should review the strengths and weaknesses of each methodology as well as the insight provided by key informants and consider how each relates to the efforts taking place in Minnesota.

BACKGROUND AND APPROACH

Methods

We conducted a review of the approaches that other states use. We reviewed waivers and other intent sources to find information about methodologies used in other states. We completed additional research from each selected waiver and choose example states to provide additional context. We also interviewed key informants.

We initially proposed to review individual budget models used across the US for people with disabilities, including individuals with intellectual and developmental disabilities, nursing care needs, traumatic brain injury, mental illness, or behavioral health needs.

The review was expected to cover the following topics:

- The target group or groups subject to the model
- The assessment instrument and other inputs (such as residential placement and/or age) that are used in the model to assign budgets
- The services that are covered by the model (for example, it is common for certain services—such as environmental or vehicular modifications—to be approved outside of the budget model)
- The approach or framework of the model (e.g., a statistical formula)
- The methods used to develop the model • The data used to inform the model (e.g., particular items embedded within an assessment tool, historical costs, anticipated service use) • The manner in which the model is applied to individuals who choose to self-direct services, as applicable
- The rationale and written description of the model provided in HCBS waivers approved by CMS
- The process for considering appeals to the results of the model • The public opinion regarding the model

As a starting point, we collected and reviewed all approved and applicable Medicaid Section 1915(c) waivers that served Aging, Physical Disabilities, Intellectual and/or Developmental Disabilities, Traumatic Brain Injury. We included Aging as a target population as we hoped to increase the number of results. We removed waivers that were not 1915(c) waivers, or that were targeted to any of the following populations:

- HIV/AIDS
- Maternal Health/Pregnancy
- Dysautonomia

- Cystic Fibrosis
- Pediatric Palliative Care
- Family Planning
- Medical Day Care
- Mental Health
- Children with SED/PRTF

Waivers that were pending, expired, or terminated were also excluded. Additionally, waivers that were not available of Medicaid.gov were not considered for this preliminary review.

In particular, Appendix C-4 of the waiver application requires states to report limits that are employed within the program, including limits on sets of services, prospective individual budget amounts, budget limits by level of support, and other types of limits. According to CMS, states are required to submit this information when "a state imposes a dollar limit on the amount of waiver services that may be authorized in a service plan over and above any limits on amount, duration and frequency that apply to individual waiver services" (Centers for Medicare and Medicaid Services [CMS], 2015, p. 131).

In total we reviewed 259 waivers across all target populations. From this preliminary review, we found 29 state waivers marked "prospective budget," 34 state waivers marked "budget limit by level of support," 23 state waivers marked "limits on services," 14 state waivers marked "other limit," and 159 marked "not applicable."

Figure 10

CMS Guidance for C-4 Designations

CHECKBOX	DESCRIPTION
Prospective Budget	Methodologies that determine a specific budget amount that is uniquely assigned to each individual waiver participant. The assigned budget amount constitutes a limit on the overall amount of services that may be authorized in the service plan. This method is termed "prospective" because the amount that is assigned is determined in advance of the development of the participant's service plan.
Budget Limit by Level of Support	Methodologies that group waiver participants who share similar characteristics or support needs. States assign budget limits to each of these levels or participant groupings. These limits specify the maximum dollar amount of waiver goods and services that may be included in the service plans of participants who fall into each level or grouping."
Limits on Services	This type of dollar limit is applied to two or more waiver services, usually services that are closely related or might serve as substitutes for one another (e.g., personal care and chore services). A state may define several sets or groupings of services to which dollar limits apply.
Other Limit	If one of the pre-identified selections does not appropriately describe the dollar limits that the state applies, select "other" and describe the dollar limit that is imposed.
Not Applicable	The "not applicable" selection should be made only when no such dollar limits are applied.

(CMS, 2015, p.131-132)

We limited our remaining efforts to waivers that had the designation of "prospective budget" or "budget limit by level of support" (63 state waivers total) we took notes on the individual budget method that was indicated in the C-4 section of the waiver in an annotated excel document.

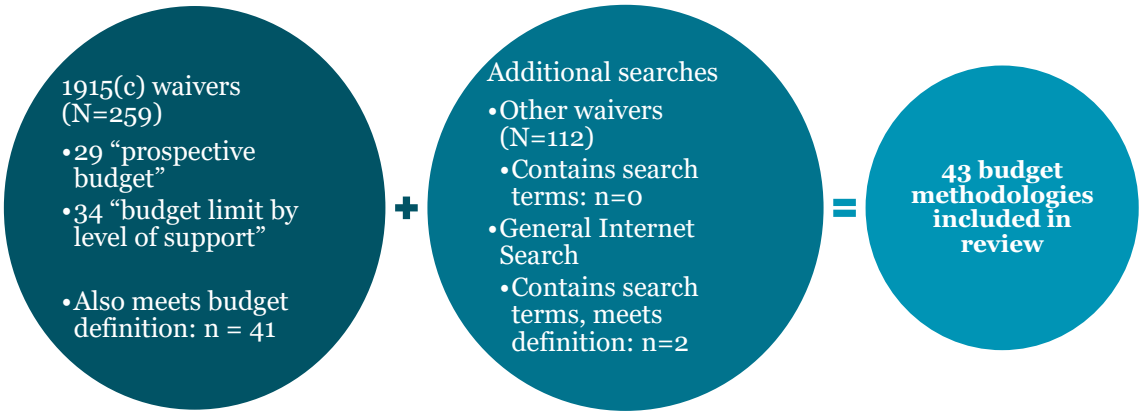
We used a series of search terms within the waiver itself to determine the exact approach that was applied. We used the following search terms:

- supports budgets
- support levels
- funding levels
- funding tiers
- prospective budgets
- individual budgets
- formula
- matrix

We added to the notes information relating to the budgets found in other sections of the waiver.

Once we had specific terms that were applied to describe the budget methodology we searched state websites and google for each of the states using a combinations of terms above and specific terms found in the waiver to describe each approach (e.g. Service Cost Maximum was described in the waiver for Illinois, so we searched for this term) often in conjunction with "disability services" or "disability waiver services", or specific disabilities that the waiver served. We collected additional information and updated our notes as necessary.

We completed two additional reviews to gather other state waivers for consideration. First, we searched all other waivers on Medicaid.gov using the search terms described above. Of 112 total waivers, no additional waivers were added. Then we searched google using all of the search terms described above except formula and matrix. We also added disability specific terminology (e.g., "Brain Injury", "Intellectual and Developmental Disabilities", "Medically Fragile", "Autism"). From this we found two additional states that had not been identified, one that has a 1915(k) waiver and one that has a 1915(c) waiver that did not have either of the required C-4 designations. We included information about these states in our notes.



At this point, our team met and decided to refine the criteria for inclusion to make sure that we only included methodologies that were aligned to the goals of Minnesota. We defined two key criteria that must be met for an approach to be considered:

- **Assessment Informed**—the state must have used a formal quantitative assessment to inform the budgets that were selected. The assessment must have been directly linked to the resulting budgets—that is items from the assessment must have informed the amounts that were indicated in the budgets.

- **Prospective Budget**—the state must have used a prospective budget—that is a budget that is known before the plan is completed to estimate needed

services over the coming year, and that is *not* developed by tallying services through the planning meeting.

We excluded those that where the assessment was qualitative or where insufficient information pertaining to the assessment could be obtained. We also excluded those where the budget was developed through planning rather than with the use of the assessment, and where there was no meaningful link between the assessment and the budget.

These criteria were chosen because they are similar to the objectives that DHS is interested in pursuing—that is DHS would like to implement an individual budget methodology that can be used to help service recipients choose which HCBS services they would like to use and that is based on support needs established with the MnCHOICES assessment, and possibly other factors.

Appendix A displays our applied decision criteria. In total there were 43 methodologies confirming to all of the above criteria.

Our team met to decide upon a number of states for further inquiry both to provide more detailed information about the approach to DHS and to ensure that the approach was described accurately. HSRI selected eight states for further inquiry. These states were selected for the approach that they used, the populations that they served, the assessment that was used, how long the approach had been used (both a mix of newly implemented and long ago implemented), demonstrated changed to the approach (to consider recalibration efforts), and in effort to show a broad range of approaches. Each state and the reasons for its inclusion is detailed below. See "Findings" for complete state profiles.

Florida—Florida was selected because it uses a formula-based approach. The approach has been updated and found to be statistically valid. There was ample publicly available information. Florida also uses an instrument that was developed uniquely for the state. This approach is used with individuals with Autism, Intellectual Disabilities, and Developmental Disabilities.

Idaho—Idaho was selected because it uses a formula-based approach that is now being changed. Idaho used a standardized instrument that is used nationally and ties the results to an algorithm. Idaho uses this approach with individuals with Autism, Intellectual Disabilities, and Developmental Disabilities. We are currently assisting Idaho to develop a new approach that will replace this approach.

Illinois—Illinois was selected because it uses an instrument that was developed uniquely for the state to assign a unique budget for each individual. This tool results in an exact amount dollar amount that is tied to each score for each service. This approach is used with Aging individuals and individuals with Physical disabilities.

Oregon—Oregon was selected because it uses an item-based approach. This approach uses a tool that was specifically developed for the state or Oregon and that is tied to exact hour amounts of services. It has been in place since 2013. This approach is used

with individuals with Intellectual and Developmental Disabilities. We are currently working with Oregon to develop a new approach that will replace this approach.

North Carolina—North Carolina was selected because HSRI has developed a levels-based approach for service recipients in North Carolina. This approach uses a standardized and validated instrument that is tied to levels and has only been implemented since 2016. This approach is used with individuals with Intellectual and Developmental Disabilities.

West Virginia—West Virginia was selected because it uses an approach that sets a base budget amount and then add on to the amount. The base budget is determined on age and living setting and the additional funding that corresponds to items in a standardized assessment that are statistically significant. This approach is used with individuals with Intellectual and Developmental Disabilities.

Wisconsin—Wisconsin was selected because it is a self-directed waiver. It uses a hybrid levels-based plus formula-based approach to determine a budget for individuals who use self-directed services with a standardized assessment. This approach is used for Aging individuals, individuals with Intellectual and Developmental Disabilities, and Individuals with Physical Disabilities.

Wyoming—Wyoming was selected because it uses a levels-based approach and has implemented individual budgets for more than 20 years. This approach ties a standardized assessment to levels of support that are tied to funding limits. This approach is used for individuals with Brain Injury, Intellectual Disabilities, and Developmental Disabilities.

After each state was chosen for additional inquiry, we attempted to locate an individual who could speak with us about how the approach was developed, what the approach entails, obstacles encountered in implementing the approach, opportunities resulting from the implementation of each approach, additional resources that described the approach, and specific questions based on our research. Initially we attempted to call individuals, most often state directors to set up an interview. We did not reach any individuals by phone but were often directed to specific individuals for follow-up contact. We followed up by email to either our initial contact, or another individual whom we were referred. In total, we conducted seven interviews of state staff.

We also chose not to interview North Carolina about their approach since we assisted the state in developing the approach and are currently working with the state in their implementation. Since we have worked with a number of these states we have restricted what is reported in the state profile to information that is publicly available and general information that we learned from speaking with state staff or from our own experience.

For each of the interviews we asked state staff if Minnesota DHS staff could participate in the interview. Staff participated in each interview to gain clarity on the approach, to have an opportunity to ask additional questions, and to use what they

learn to further future discussions about the course the DHS will take in developing its own methodology.

Two state profiles are not included in this report. We did not believe that we had adequate information about Illinois or Wisconsin to include in this report.

Limitations

The limitations of our methods primarily related to what was publicly available and accessible. We began our research by looking into states with 1915(c) waivers since there was a readily available source from which to determine whether a budgeting methodology was used. This narrowed the available results since not all states that serve similar target populations and that may be using an assessment informed prospective budget may not use this authority to fund services.

Another limitation pertained to the quality of the information that was retrieved. Since we were dependent on the Medicaid waiver containing specific information, when this information was not accurate or limited, it meant that we had to complete additional searches to gain the information. These additional searches often offered only limited supplementary materials and, in many cases, did not add heft to the original information found about the methodology within the waiver. When we engaged in google, these most often lead to approaches that we had already identified, but rarely yielded new information.

Finally, our search was limited not only to the populations served, but also the existing methodologies. As a result, while we attempted to include methodologies that were used across multiple populations, our search revealed methodologies mostly used with individuals with IDD. As a result, this target population is widely represented within this report. We explored options to gain insight into additional target populations, but our exploration led us to believe that some of the target populations, but these largely did not meet the criteria that we established for this review. For example, we spoke with experts on self-direction, mental health, cash and counseling, fiscal management entities, and TBI. Each conversation ended with some suggestions for additional inquiry, and a broad understanding that we were unlikely to uncover additional information. There are many approaches that set capitations on funding, and these are used across a range of target populations. By and large, the funding approaches are not tied to an assessment, and are set based on either what an individual received in the past, by determining the amount of funding available and spreading it across service recipients, or simply choosing an amount. Since these approaches are not consistent with the direction that DHS is pursuing, they were not included in these results.

Appendices

Appendix A: Included Methodologies

Waiver	Waiver Type	Population	C-4 Designation	Assessment Informed Prospective Budget	Individual or Level
AR Alternative Community Services	1915(c)	Individuals with autism, ID, DD ages 0 - no max age	Budget Limits by Level of Support	X	L
CA Assisted Living	1915(c)	65+ Physical or other disability ages 21-64	Prospective Budget	0	NA
CA San Francisco Community Living Support Benefit	1915(c)	65+ Physical or other disability ages 21-64	Prospective Budget	0	NA
CA In Home Operations	1915(c)	Medically fragile and tech dependent ages 0 - no max age	Prospective Budget	0	NA
CO Children's Autism Waiver	1915(c)	Autism ages 0-5	Prospective Budget	0	NA
CO Children's Extensive Support	1915(c)	Individuals w/DD ages 0 - 17	Prospective Budget	0	NA
CO Supported Living Services	1915(c)	Individuals with DD ages 18 - no max age	Budget Limits by Level of Support	X	L
CT Employment and Day Supports	1915(c)	individuals w/DD ages 18 - no max age and ID ages 3 - no max age	Budget Limits by Level of Support	X	L
CT HCBS Community Supports for Persons with Autism	1915(c)	Autism ages 3 - no max age	Budget Limits by Level of Support	X	L
CT Individual and Family Support	1915(c)	Individuals with DD ages 18 - no max age, ID ages 3 - no max age	Budget Limits by Level of Support	X	L

Waiver	Waiver Type	Population	C-4 Designation	Assessment Informed Prospective Budget	Individual or Level
CT Comp Supports	1915(c)	DD ages 18 - no max age, ID 3 years - no max age	Budget Limits by Level of Support	X	L
FL DD Individual Budgeting	1915(c)	Autism, ID, DD ages 3 - no max age	Prospective Budget	X	I
GA New Options Waiver	1915(c)	Individuals with DD/ID ages 0 - no max age	Prospective Budget	X	L
ID Developmental Disabilities Waiver	1915(c)	Autism, DD, ID, ages 18 - no max age	Prospective Budget	X	I
ID Children's DD waiver	1915(c)	Autism, ID, DD ages 0-17	Budget Limits by Level of Support	X	L
ID Act Early Waiver	1915(c)	Autism, DD, ID ages 3-6	Budget Limits by Level of Support	X	L
IL Elderly Waiver	1915(c)	65+ Physically disabled ages 60-64	Budget Limits by Level of Support	X	L
IL Support Waiver for Children and Young Adults with Developmental Disabilities	1915(c)	Autism, ID, and DD ages 3-21	Prospective Budget	0	NA
IN Community Integration and Habilitation	1915(c)	Autism, ID, DD ages 0 - no max age	Budget Limits by Level of Support	X	L
IN Family Supports	1915(c)	Individuals w/autism, ID, DD ages 0 - no max age	Prospective Budget	0	NA
IA HCBS Intellectual Disabilities	1915(c)	Individuals with ID ages 0 - no max age	Prospective Budget	X	L
LA Community Choices	1915(c)	65+ Physical disability 21-64	Budget Limits by Level of Support	X	I
LA Residential Options Waiver	1915(c)	Autism, ID, DD ages 0 - no max age	Budget Limits by Level of Support	X	L
ME HCBS for Member with Brain Injury	1915(c)	Individuals with brain injury ages 18 - no max age	Prospective Budgets	X	I

Waiver	Waiver Type	Population	C-4 Designation	Assessment Informed Prospective Budget	Individual or Level
ME HCBS for Adults with Other Related Conditions	1915(c)	65+ Other disabilities ages 21-64	Prospective Budgets	0	NA
MA Children's Autism	1915(c)	Autism ages 0 - 8	Prospective Budgets	0	NA
MA Adult Supports	1915(c)	Individuals with ID 22 - no max age	Prospective Budgets	0	NA
MA Community Living	1915(c)	Individuals with ID ages 22 - no max age	Prospective Budgets	0	NA
MS Intellectual Disabilities	1915(c)	Autism, DD, ID ages 0 - no max age	Budget Limits by Level of Support	X	L
MT Supports for Community Work and Living	1915(c)	Individual with ID, DD ages 16 - no max age	Budget Limits by Level of Support	0	NA
MT HCBS for Individuals with DD	1915(c)	Individuals with ID, DD ages 0 - no max age	Budget Limits by Level of Support	0	NA
NE Comprehensive DD Waiver for Adults	1915(c)	Autism, MR, DD, ages 21 - no max age	Prospective Budgets	X	I
NE Comprehensive DD Services	1915(c)	Autism, ID, DD ages 0 - no max age	Prospective Budgets	X	I
NE DD Day Services Waiver for Adults	1915(c)	Individuals with autism, ID, DD ages 21 - no max age	Prospective Budgets	X	I
NH In Home Supports for Children with DD	1915(c)	Autism, ID, DD ages 0 - 21	Prospective Budgets	0	NA
NJ Community Care Waiver	1915(c)	Autism, ID, DD 21 - no max age	Budget Limits by Level of Support	X	L
NM Mi Via	1915(c)	Medically fragile, Autism, DD, ID, ages 0 - no max age	Prospective Budgets	0	NA
NM Medically Fragile	1915(c)	Medically fragile ages 0 - no max age	Budget Limits by Level of Support	X	L

Waiver	Waiver Type	Population	C-4 Designation	Assessment Informed Prospective Budget	Individual or Level
NM DD Waiver Program	1915(c)	Autism, ID, DD, ages 0 - no max age	Budget Limits by Level of Support	0	NA
NY Long Term Home Health Care Program	1915(c)	65+ Physically disabled ages 0-64	Budget Limits by Level of Support	X	L
NC Innovations Waiver	1915(c)	Individuals with ID, DD ages 0 - no max age	Budget Limits by Level of Support	X	L
NC 2008 CAP/DA	1915(c)	65+ Physically disabled 18-64	Budget Limits by Level of Support	X	L
ND Medicaid Waiver for Medically Fragile	1915(c)	Medically fragile ages 3-17	Prospective Budgets	0	NA
ND Medicaid Waiver for HCBS	1915(c)	65+ Physically disabled ages 18-64	Prospective Budgets	X	I
OH Transitions DD	1915(c)	Autism, DD ages 0 - no max age	Budget Limits by Level of Support	X	L
OH Self Empowered Life Funding	1915(c)	Individuals with ID, DD ages 0 - no max age	Prospective Budgets	0	NA
OH Transitions II Aging Carve Out	1915(c)	65+ Physically disabled 60-64	Budget Limits by Level of Support	X	L
OH Individual Options	1915(c)	Individuals ID, DD, ages 0 - no max age	Budget Limits by Level of Support	X	L
OH Home Care	1915(c)	Physical disabilities ages 0-59	Budget Limits by Level of Support	0	NA
OR K-Plan	1915(k)		NA Internet Search	X	I
TN Self-determination waiver	1915(c)	Individuals with ID ages 0 - no max age, DD ages 0 - 5	Prospective Budgets	0	NA
UT Physical Disabilities	1915(c)	65+ Physically disabled 18-64	Prospective Budgets	X	I
VA Building Independence Waiver	1915(c)	Autism, ID, DD ages 18 - no max age	Budget Limits by Level of Support	X	L

Waiver	Waiver Type	Population	C-4 Designation	Assessment Informed Prospective Budget	Individual or Level
VA Family and Individual Waiver	1915(c)	Autism, ID, DD ages 0 - no max age	Budget Limits by Level of Support	X	L
VA Community Living Waiver	1915(c)	Autism, ID, DD ages 0 - no max age	Budget Limits by Level of Support	X	L
WA Individual and Family Support	1915(c)	DD ages 3 - no max age	Budget Limits by Level of Support	X	L
WA Basic Plus Waiver	1915(c)	Autism, ID, DD ages 0- no max age	Budget Limits by Level of Support	X	I
WA Core Waiver	1915(c)	Autism, ID, DD ages 0 - no max age	Budget Limits by Level of Support	X	L
WA Community Protection Waiver	1915(c)	Autism, ID, DD ages 18 - no max age	Budget Limits by Level of Support	0	NA
WI Elderly and Physically Disabled	1915(c)	65+ Physically disabled ages 18-64	Budget Limits by Level of Support	X	L
WV Intellectual Developmental Disability	1915(c)	Individual with ID, DD ages 3-no max age	NA Internet Search	X	L
WY Comprehensive	1915(c)	Individuals with BI 21 - no max age, ID, DD 0 - no max age	Prospective Budgets	X	L
WY Acquired Brain Injury	1915(c)	Individuals with brain injury ages 21 – 64	Prospective Budgets	X	L
WY Supports	1915(c)	Individuals with ID, DD ages 0 - no max age	Prospective Budgets	0	NA

Appendix B: CMS Approved Funding Descriptions for Example States

Florida Developmental Disabilities Individual Budgeting Waiver

This waiver provides each recipient a prospective individual budget amount. Additional funding will be provided for recipients whose needs are so extraordinary that the use of this approach is inappropriate or who experience one-time needs or changes in needs that cannot be accommodated within the individual budget. The algorithm and methodology will determine the budget for all of a recipient's waiver services. The recipient may not exceed this budget amount for paid waiver services.

The algorithm was developed by a Ph.D.-level statistician with stakeholder input using multiple regression techniques to equitably distribute available funds based on historical funding patterns. The algorithm considers individual recipient characteristics which are statistically proven to correlate with costs and generates a budget amount for each person prior to the support planning process. The data used in the algorithm is reliable and valid, and its sources include the agency's client database and the agency-approved needs assessment instrument. Factors considered by the algorithm include age, living setting, and results from the agency's needs assessment instrument. The weight of these factors in the algorithm is based on the nature of their relationship with the historical costs for individuals enrolled in the developmental disabilities waiver; those with the greatest relationship to costs have the most weight in the algorithm.

The methodology for determining an individual budget is open for public inspection in the following ways. Prior to finalizing the methodology for determining an individual budget, APD convened a formal workgroup comprised of representatives from key stakeholder groups, including self-advocates, families with loved ones receiving waiver services, those on the waitlist, waiver support coordinators, independent waiver support coordinators, and other members from the public. In addition, the specific criteria for determining the individual budget amount is provided in Rules 65G-4.0210(2), and 65G-4.0212, F.A.C. This state rule is published online and was subject to public input during the rule promulgation process.

APD determines each recipient's budget amount using the funding formula and algorithm. Some recipients have extraordinary needs that do not fit a formula. Also, all recipients are subject to unplanned, temporary service needs and changes in their personal circumstances that require reexamination of their budget. That change may be temporary or permanent. It may require a one-time expenditure or a permanent budget adjustment. Accordingly, this waiver makes provision for these needs through reserving a portion of the overall agency budget to meet them. The agency may approve an increase to the amount determined by the funding formula prior to notifying the recipient of their budget amount, or recipients may apply to access these additional funds.

If service needs increase beyond the maximum annual dollar amount assigned to a recipient or if there is a documented change in circumstance, the recipient will be evaluated using the APD approved assessment and other processes for a potential increase in the budget amount.

Recipients will receive an evaluation using the APD approved assessment. The results of the assessment, along with other information required by the algorithm, will be used to determine the recipient's budget amount. All recipients will receive written notification of the maximum annual dollar amount assigned to that recipient. Recipients will also receive written notice with instructions should they wish to request a fair hearing regarding the determination.

A calculation tool establishes a budget based on information entered on an Inventory of Individual Needs, an assessment tool designed to capture the participant's functional abilities, behavioral limitations, medical needs and other individual factors related to their developmental disability. The tool is based on a regression analysis model which calculates a budget that correlates with each participant's individualized needs.

The budget tool is periodically evaluated and adjusted to ensure participant budgets are calculated using information that produces the greatest statistical validity when analyzing participant need and cost of services.

To ensure a participant's budget is adequate to meet their individual needs, Idaho provides the following safeguards:

1) When the participant is noticed regarding their budget amount they have the opportunity to appeal that budget within 28 days of the date on the eligibility notice. When the appeal is received it is reviewed by the Department to ensure all the participant's needs were accurately captured through responses on the inventory of individual needs and the participant does not have needs outside of what is captured by the inventory that meet medical necessity criteria. If there are medically necessary services that are needed to ensure a participant's health and safety, but the need for such service is not addressed by the inventory, dollars to meet those needs are added to the budget. Individualized budgets will be re-evaluated annually.

2) At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria and are necessary to ensure a participant's health and safety, and this is not reflected on the current inventory of individual needs. When the Department determines there has been a documented change in condition not reflected on the current inventory, a new inventory is completed and budget calculated for the participant. The participant has the right to appeal this new budget.

3) A participant may submit a service plan requesting a combination of DD services that exceed their annual calculated budget if the participant is eligible for High or Intense Residential Habilitation Supported Living services, and the combination of services on the plan is medically necessary and necessary to ensure the health and safety of the participant.

4) A participant may submit a service plan requesting a combination of services that exceeds their annual calculated budget when the request for additional budget dollars is associated with services to obtain or maintain employment and meets criteria defined in Department rule. The participant, person centered planning team and plan developer will identify what employment services are needed to meet the participant's goals at the time of annual plan development or when a service plan is adjusted during the year. If, through these processes, it is identified that a participant may require a budget modification in order to maintain or obtain employment, the plan developer will assist the participant in requesting an Exception Review.

For participants requesting an exception review, plan developers will submit a Department approved Exception Review form and supporting documentation along with the annual plan of service or addendum. Exception review requests will be reviewed and approved by Department Case Managers based on the following:

1. A Supported Employment service recommendation including the recommended amount of service, level of support needed, employment goals and a transition plan designed to facilitate the participant's

independence in their work environment which includes criteria on how the participant will transition to less dependence on paid supports. The Supported Employment recommendation shall accompany the Exception Review Request and must be completed by the Idaho Division of Vocational Rehabilitation (IDVR) when the participant is transitioning from IDVR services or by the Supported Employment Agency identified on the plan of service or addendum

2. The participant's plan of service has been developed by the participant and their person centered planning team to support employment as a priority. Exception reviews submitted with an addendum should include service modifications to accommodate the addition or increase of Supported Employment services. If no service modifications are made to accommodate the addition or increase of Supported Employment services, the person centered planning team will identify the reasons for the ongoing need for the requested mix of services.

3. Acknowledgement that additional budget dollars approved to purchase Supported Employment services may not be reallocated to purchase any other Medicaid service signed by the participant and legal guardian if one exists.

Requests for an exception review for annual plans must be submitted within forty-five (45) days prior to the expiration of the existing plan. Adjustments to the plan of service can be made throughout the year through an addendum to the Plan of Service. Requests for an exception review for addendums must be submitted 15 days prior to the anticipated start date of the modified service.

Oregon K Plan

Not well described in K plan amendment. Information largely obtained from internet.

North Carolina Innovations

Budget Limit by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limited on the maximum dollar amount of waiver services. Furnish the information specified above.

Transition to PIHP from the Comprehensive and Supports Waivers:

All waiver participants transitioning to Innovations from the CAP-MR/DD Comprehensive and Supports waivers (0662 and 0663) have an individual budget that is a projection of the services and supports identified in the Individual Support Plan. The budget (cost summary) reflects a summary of the frequency and duration of each medically necessary service or support described in the CAP-MR/DD Plan of Care. For these individuals, the CAP-MR/DD budget amount will become the new individual budget amount once transitioned to the PIHP. The NC Innovations waiver will not include the current targeted Case Management service; Treatment Planning case management will be provided by Care Coordinators.

The newly transitioned individual budgets will be used until the needed Supports Intensity Scale assessments and Support Needs Matrix category budgets can be developed which is anticipated to take a minimum of 24 months. During this transition, the individual budget will reflect base budget services and non base budget services, in combination not to exceed the $135,000 cost limit, as an educational tool to prepare for transition to the Support Needs Matrix.

Waiver participants in the original Cardinal Innovations Healthcare Solutions (formerly, PBH) geographic area:

All waiver participants are assigned to a Support Needs Matrix category on either the Residential Support Needs Matrix or the Non-Residential Support Needs Matrix (collectively referred to as the "Support Needs Matrix"). The Residential Support Needs Matrix is applied to those individuals that require residential services and the Non-Residential Support Needs Matrix is applied to those individuals that do not require residential services.

Basis of the Budget Limit:

The Support Needs Matrix is designed to standardize funding among persons who have similar support (acuity) needs and reflects: assessment derived categories of need, age, and budget limit.

The assessment instrument used to objectively measure individual support needs is the Supports Intensity Scale (SIS) assessment tool developed by the American Association on Intellectual Disabilities and Developmental Disabilities (AAID). The SIS is a valid, reliable instrument for assessing the level of an individual's support needs in major domains of daily living as well as behavioral and medical needs. The SIS has been in use by the original demonstration PIHP, Cardinal Innovations Healthcare Solutions, for 4 years. Cardinal Innovations Healthcare Solutions is a national norming site for the child version (for children below the age of 16) of the SIS. Extensive training of a dedicated team of local SIS interviewers has been successfully completed by two of the SIS authors. This training included both the adult version of the SIS and the child version of the SIS. The SIS has been enhanced by supplemental questions that include four topics: community safety risk (convicted and not convicted), extreme self-injury risk, and extraordinary medical care (risk) for individuals whose supervision for those concerns requires 24 hour eyes on supervision. Individuals who are at high need/risk in these categories receive services within the top two budget categories.

The categories of need (Categories A-G) were adopted from work performed by other jurisdictions employing the SIS as the assessment instrument in resource allocation models. These categories were derived based on the SIS assessments, additional information concerning the participants' living arrangement (e.g., lives with family or resides in a community residential setting) and the amount of service expenditures for the individuals assessed.

The specific categories of need were derived in other jurisdictions by employing multiple regression analysis and other statistical techniques to identify SIS elements that were statistically significant in explaining differences in service expenditures. The category of need algorithm used by these other jurisdictions have satisfactorily explained differences in funding authorizations that stem from differences in objectively assessed support needs.

The Support Needs Matrix divides the population by age into adults and children. Children are defined in the Support Needs Matrix as less than 22 years of age and adults are defined in the Support Needs Matrix as 22 years of age or over.

The budget limit for each cell of the Support Needs Matrix were developed based on an analysis of historical expenditures of the "Base Budget Services" for individuals participating in NC Innovations, guideline service packages and provider rates paid by the PIHP.

The most recent local SIS interviews from the previous calendar year are made into SIS informed categories during the first quarter of the new calendar year. The SIS tool is administered to all waiver participants at least every three years for adults and every two years for children. New budget limits will be used in the categories on July 1 of each year. The Support Needs Matrix will be phased in as resources permit during a

period not to exceed three years. At the end of the three years the Support Needs Matrix will be applicable for all waiver participants.

Services Included in the Support Need Matrix:

Waiver services defined as "Base Budget Services" are included in the cost limit of the Support Need Matrix. "Base Budget Services" are:

1. Community Networking Services
2. Day Supports
3. In-Home Skill Building,
4. Intensive In-Home Supports
5. Personal Care
6. Residential Supports
7. Respite
8. Supported Employment

Waiver services not included in the definition of "Base Budget Services" are:

1. Assistive Technology Equipment and Supplies
2. Community Guide Services
3. Community Transition Services
4. Crisis Services
5. Financial Support Services
6. Individual Goods and Services
7. Home Modifications
8. Natural Supports Education
9. Specialized Consultation Services
10. Vehicle Modifications

The services in "Base Budget" and the services not included in the "Base Budget" together may not total more than the Cost Limit of $135,000.

Individual Budget:

The budget limits in the Support Needs Matrix are the maximum Individual Budget amount that can be authorized for Base services in a waiver participant's Individual Support Plan.

The Care Coordinator (Case Manager), as part of the Individual Support Plan development, will explain the Support Needs Matrix, the development process and maximum amount of the Individual Budget, the service authorization process, the mechanisms available to the participant/representative to modify their Individual Budget and the participant's rights to a Fair Hearing.

A result of the Individual Support Plan development is an Individual Budget that is a component of their Individual Support Plan (ISP). The Support Needs Matrix Category Budget, once authorized, will represent the total cost of "Base Budget Services" under the waiver to be delivered under the Individual Support Plan. All Individual Budgets are reviewed by the PIHP Utilization Management Department for final determination and authorization of funding.

In developing the Individual Support Plan and the Individual Budget, the planning team will be guided by the person's support needs as identified in the SIS assessment and their selection of living arrangement. The

person's support needs and their living arrangement will be used to identify the category of need assigned to the participant and the cost limit associated with that category of need in the Support Needs Matrix. The strength of the Support Needs Matrix is that each individuals' identified category is based on their assessed support needs and community living arrangement choice. The Care Coordinator will guide the development of the Individual Support Plan, based on assessed need and living arrangement, such that the resulting Individual budget for "Base Budget Services" is at or below the appropriate cost limit in the Support Needs Matrix.

Adjustments for Individual Circumstances:

The Care Coordinator will call an ISP review meeting in the event of an increased need for service by a waiver participant. If the interdisciplinary team review determines a need for increased intensity of services, the PIHP Utilization Management Department or designee may approve a time limited, temporary, (not to exceed six months) increase in intensity of services. Temporary increases are unplanned/unexpected circumstances that change the participant's support needs for a time-limited period.

If the interdisciplinary team determines that a waiver participant has an extended need for an increased intensity of supports needs, this will be considered a permanent support needs, (beyond six months), the individual may be authorized a change in living arrangement (from home to a community based residential facility or from a community based residential facility to home) which will move the participant between the Non-Residential Support Needs Matrix and the Residential Support Needs Matrix; or the participant may be re-assessed and, if supported by the results of a new SIS assessment, moved to a higher category of support need. If the cost limits in the new living arrangement or category of support need will not meet the participant's support needs, the participant may seek approval for placement in the Intensive Review Category.

If the Individual Budget and Individual Support Plan cannot be developed for Base Budget Services at or below the Budget limit, the Care Coordinator will prepare a justification for placement of the participant into the Intensive Review Category based on the unique behavioral, safety, health and/or welfare support needs of the individual (that are distinguished from the support needs of other waiver participants in the same Support Need Matrix cell) and request review by the Intensive Review Committee prior to submission of the Individual Support Plan and the Individual Budget to the PIHP Utilization Management Department.

If the Intensive Review Committee determines that the support needs for the participant requesting placement into Intensive Review category that fall significantly outside usual and customary support needs for their assigned category, the participant will be included in Intensive Review and the Individual Budget developed by the planning team will be approved.

Adjustments to the Budget Limits in the Support Need Matrix:

The Budget limits in the Support Needs Matrix will be adjusted in future years to reflect the service component of the approved capitation rate paid for this waiver. In the event that the service component of the approved capitation rate paid for this waiver is less than or more than the weighted average Support Needs Matrix budget limits (plus an allowance for services that are not included in "Base Budget Services"), all budget limits will be uniformly adjusted on a percentage basis to meet the capitation rate. The service component of the approved capitation rate is the total capitation rate less amounts for administration, risk, and services not included in the 1915(c) waiver.

In addition, the overall Support Needs Matrix will be periodically evaluated to confirm that the underlying elements upon which it is based continue to be reliable predictors of necessary resources based on

assessed support needs. In the event that the categories of need in the Support Needs Matrix are modified as a result of this evaluation or based on experience, the State will submit a waiver amendment to CMS before implementation.

Self Direction:

Participants who self-direct one or more waiver services are subject to the cost limits of the Support Needs Matrix in the same manner as other waiver participants. The amount assigned to the Individual and Family Directed Budget will be based on the cost of the Base Budget Services they choose to self-direct. See Appendix E for services that may be self-directed and details and self-direction in the NC Innovations Waiver.

Availability of Methodology:

A description of the methodology used by the other jurisdictions to develop the categories of need algorithm is available to CMS upon request. The methodology for determining the Support Needs Matrix is available for public review and inspection upon request from the PIHP.

Participant Safeguards:

If the planning team determines that a waiver participant has an extended/permanent need for an increased intensity of services (beyond six months), the individual may be authorized for a change in living arrangement (from home to a community residential facility) which will move the participant from the Non-Residential Support Needs Matrix to the Residential Support Need Matrix or reassessed and if supported by the results of a new SIS assessment, moved to a higher category of support need. If the cost limit in the new living arrangement or category of support need will not meet the participant's needs, the participant may seek approval for placement in Intensive Review.

If the Support Needs Matrix category budget and the Individual Support Plan cannot be developed for Base Budget Services at or below the cost limit, the Care Coordinator will prepare a justification for placement of the participant into Intensive Review based on the unique behavioral, safety, health and/or welfare support needs of the Individual (that are distinguished from the support needs of other waiver participants in the same Support Need Matrix category) and request review by the Intensive Review Committee prior to submission of the Individual Support Plan and the Individual Category Budget to the PIHP Utilization Management Department.

If the Intensive Review Committee determines that the support needs for the participant requesting placement into Intensive Review fall significantly outside usual and customary support needs, the participant will be included in the Intensive Review category and the Support Need Matrix Category Budget developed by the planning team will be approved.

If a participant's support needs cannot be met through a time limited (temporary) increase in intensity of services, a movement from the Non-Residential Support Needs Matrix to the Residential Support Needs Matrix or has not been approved for placement into the Intensive Review category the participant will be referred to an ICF/MR facility.

The individual and their planning team will create a new, person focused Individual Support plan supported by the new Support Needs Matrix funding category. This is in line with the individual's pursuit of self-direction and a life integrated in their local community.

As reported in Appendix B-2 Individual Cost Limit, the participant will be referred to an ICF-MR as their care cannot be met within the $135,000 cost limit.

Transition to PIHP from the Comprehensive and Supports Waivers:

Comprehensive and Supports waiver participants will use their current CAP-MR/DD budgets to ensure a seamless transition into the NC Innovations waiver until the needed SIS assessments and Support Needs Matrix category budgets can be developed.

West Virginia Intellectual/Developmental Disabilities Waiver

Appendix C-4 is marked not applicable

Wyoming Adult Developmental Disabilities Waiver

The DD Division limits the maximum dollar amount of waiver services authorized for each ABI Waiver participant using a prospective individual budget amount. The prospective individual budget amount is based upon historical annual plan units multiplied by the posted service rates. The rates for all ABI Waiver services are posted on the DD Division website. For new participants, the limit is based upon core services multiplied by projected units as determined using the ICAP assessment and information from the case manager to determine service needs.

Participants, guardians and case managers are notified by letter of a participant's individualized budget amount when the participant is provided a funding opportunity on the ABI Waiver, and whenever there are changes to the individualized budget amount. The budget limit methodology may be adjusted over the course of the waiver period due to increases or decreases in posted rates and/or increases or decreases in funding appropriations.

Once the individualized budget is first determined or is changed, the participant, the case manager and the team work together to develop or revise the plan of care so that needed waiver services are allocated within the individualized budget and non-waiver services are identified. The individualized budgeted amount does not limit specific waiver services. If the participant and/or guardian, with support from the team, identifies that the plan of care developed within the budgeted amount will not meet the participant's health and welfare needs the case manager can request additional funding on behalf of the participant through the DD Division's Extraordinary Care Committee.

The DD Division's Extraordinary Care Committee has the authority to evaluate and approve requests for additional funding above a participant's individualized budget amount due to emergency requests, a material change in circumstance, a potential emergency or other condition justifying an increase in funding. The Extraordinary Care Committee's membership includes the Waiver Manager, the DD Division's Fiscal Manager, and a representative of the State Medicaid Agent. The committee reviews the ECC request and information compiled by the participant's case manager, which must detail the reasons for the needed increase in funding and an explanation for the person's specific health and welfare needs not being adequately addressed within the individualized budgeted amount or through other non-waiver resources or supports. In some instances, the participant may be denied additional funding but may be directed to enroll in other available programs or resources to meet his/her needs in lieu of waiver funding. In these cases the participant and/or guardian is notified by letter they have a right to request a fair hearing.

The process for determining a participant's individualized budgeted amount is made available through a memorandum to stakeholders, which includes participants, guardians, and providers. An ECC database is maintained by the DD Division, which summarizes the decision of all requests, including if the decision and funding is time-limited. The ECC policy, procedure and forms for requesting additional funds are available on the Division's website for public viewing and use.

Appendix C: References

Agency for Persons with Disabilities. (2009). Report to the Legislature on the Agency's Implementation of the Questionnaire for Situational Information Assessment. Tallahassee: State of Florida.

Bruininks, R. H., Hill, B. K., Weatherman, R. F., & Woodcock, R. W. (1986). Inventory for client and agency planning. Allen, TX: DLM Teaching Resources.

Centers for Medicare and Medicaid Services. (2015). Application for a 1915(c) Home and Community Based Waiver Instructions, Technical Guidance, and Review Criteria. Retrieved from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf

Oregon Department of Human Services (n.d.a) Adult In-Home Needs Assessment ANA Version C-103. Retrieved from https://www.dhs.state.or.us/spd/tools/dd/bpa/

Oregon Department of Human Services (n.d.b) Children In-home Needs Assessment CAN Version C 103. Retrieved from https://www.dhs.state.or.us/spd/tools/dd/bpa/

Florida Agency for Persons with Disabilities. (2017). http://apdcares.org/.

Harries, J. A. (2008). Support Needs Assessment for Individuals with Intellectual Disabilities: An Investigation of the Nature of the Support Needs Construct and Disability Factors that Impact on Support Needs. Dissertation submitted to University of Adelaide.

Havercamp, S. (2009a). Evaluating the Reliability and Validity of the Questionnaire for Situational Information: Item Analyses. Tallahassee: Florida Agency for Persons with Disabilities.

Havercamp, S. (2009b). Evaluating the Reliability and Validity of the Questionnaire for Situational Information: Inter-Interviewer Reliability. Tallahassee: Florida Agency for Persons with Disabilities.

Havercamp, S. (2009c). Evaluating the Reliability and Validity of the Questionnaire for Situational Information: Test-Retest Reliability. Tallahassee: Florida Agency for Persons with Disabilities.

Havercamp, S. (2009d). Evaluating the Reliability and Validity of the Questionnaire for Situational Information: Concurrent Validity. Tallahassee: Florida Agency for Persons with Disabilities.

Idaho Department of Health and Welfare. (2009). Adults with Developmental Disabilities Individualized Budget Model Analysis. Retrieved from

https://healthandwelfare.idaho.gov/Portals/0/Medical/DevelopmentalDisabilities/AdultDDIndividulizedBudgetModelAnalysis.pdf

Idaho Department of Health and Welfare. (n.d.) DD Services for Parents: Frequently Asked Questions. Retrieved from https://healthandwelfare.idaho.gov/Portals/0/Medical/DevelopmentalDisabilities/DD%20Services%20for%20Particiipants.pdf

Institute on Community Integration. (2016a). RISP Profile 2016 Oregon. Retrieved from https://risp.umn.edu/sites/risp.umn.edu/files/2018-03/Oregon-RISP-2016.pdf

Institute on Community Integration. (2016b). RISP Profile 2016 Idaho. Retrieved from https://risp.umn.edu/sites/risp.umn.edu/files/2018-03/Idaho-RISP-2016.pdf

Institute on Community Integration. (2016c). RISP Profile 2016 West Virginia. Retrieved from https://risp.umn.edu/sites/risp.umn.edu/files/2018-03/WestVirginia-RISP-2016.pdf

Larson, S., Eschenbacher, H., Anderson, L., Taylor, B., Pettingell, S., Hewitt, A., . . . Bourne, M. (2018). In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2016. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

Minnesota Department of Human Services MR/RC CDCS Budget Methodology Workgroup. (2005). Final Report.

Minnesota Department of Human Services. (2018a). LTC Screening Document. Retrieved from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3427-ENG

Minnesota Department of Human Services. (2018b). AC, BI, CADI, EW Case Mix Classification Worksheet. Retrieved from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428B-ENG

Minnesota Department of Human Services. (2017a). CDCS Budget Methodology for the DD Waiver. Retrieved from https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-294529#

Minnesota Department of Human Services. (2017b) CDCS Lead Agency Operation Manual. Department of Human Services, State of Minnesota.

Minnesota Department of Human Services (2017c). CDCS Budget Methodology for the BI, CAC and CADI Waivers. Retrieved from: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-294528#

Minnesota Department of Human Services. (2014). DD Screening Document. Retrieved from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3067-ENG

Nisbet, P. (2017, October 18). Intellectual/Developmental Disabilities Waiver (IDDW): New Budget Methodology and Service Authorization Process. West Virginia: Department of Health and Human Resources Bureau for Medical Services Home and Community-Based Services.

Niu, X.-F., & Bell, L. (2010). Statistical Models for Predicting Resource Needs and Establishing Individual Budgets for Individuals served by the Florida Agency for Persons with Disabilities. Tallahassee: Florida Agency for Persons with Disabilities.

Niu, X.-F., & Tao, M. (2014). Evaluate and Refine the Florida APD's iBudget Algorithm. Tallahassee: Florida Agency for Persons with Disabilities.

Niu, X.-F., & Tao, M. (2015). Updated Statistical Models for the Florida APD's iBudget Algorithm. Tallahassee: Florida Agency for Persons with Disabilities.

NORC at the University of Chicago. (2014). Research Summary: ACA SECTION 2401, Community First State Plan; Oregon Amendment Summary. Retrieved from https://www.medicaid.gov/medicaid/hcbs/downloads/or-cfc-spa-matrix.pdf

North Carolina Department of Health and Human Services (n.d.). Establishing a Resource Allocation Model For Service Recipients With Intellectual and/or Developmental Disabilities Retrieved from https://www2.ncdhhs.gov/ncinnovations/pdf/Establishing_a_Resource_Allocation_031515.pdf

North Carolina Division of Medical Assistance. (2016). Medicaid and Health Choice Clinical Coverage Policy No: 8-P Retrieved from https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/8P_1.pdf

Oregon Department of Human Services (2016). Oregon 1915(k) State Plan and 1915(c) Waiver Services. Retrieved from http://www.dhs.state.or.us/spd/tools/dd/cm/k-plan-waiver-service-matrix.pdf

State of Wyoming. (2013). An act relating to the Medicaid program; providing direction to the department of health for the reform and redesign of the program. Wyoming.

West Virginia Bureau for Medical Services. (2018). Intellectual/Developmental Disabilities Waiver. Retrieved from https://dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/Pages/default.aspx

Wyoming Department of Health Behavioral Health Division. (2014, April). Understanding Your New Individual Budget Amount (IBA) for the Comprehensive Waiver.