AAIDD

Presents

Developing Individual Budgets and Reimbursement Levels Using the Supports Intensity Scale

Distinguished Faculty

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AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
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Thanks for participating in "Developing Individual Budgets and Reimbursement Levels Using the Supports Intensity Scale" on Tuesday, June 30, 2009. This manual contains important information you'll need to prepare for this conference.

YOUR CONFERENCE MANUAL

This manual contains:

- Instructions for accessing the conference
- Speaker bios and contact information
- Tips for submitting questions to speakers

CONFERENCE DETAILS

Your conference will be held Tuesday, June 30, 2009 at 2:00 p.m. EDT, 1:00 p.m. CDT, 12:00 p.m. MDT, and 11:00 a.m. PDT. The conference will last 90 minutes.

If you are using a speakerphone, put the phone on MUTE for the best sound quality.

HOW TO JOIN THE CONFERENCE

Audio

-Dial **1-866-686-6233** approximately 5-10 minutes before the start of the conference.
-Enter PIN 4798.
-You will hear music on hold until the conference has started, or be connected directly if it has already begun.
--If you have trouble with your phone access, stay on the line and an operator will assist you.

If you are disconnected at any point during the call, just call back and repeat the process.

Web

-Go to http://www.meetingmagnet.com/ws.
-Enter conference ID 4798.
-Leave access code blank.
-Enter name, company and e-mail.
-Click **log on** to join conference.

HOW TO SUBMIT QUESTIONS TO PANELISTS

If you wish to submit a question to our panelists, you may do so during the conference by using the chat function at the bottom of the web page (once you have logged on). This option, as well as live Q&A, will also be available during the conference.

TIPS FOR ASKING QUESTIONS

You are on "listen only" mode unless you choose to participate in the live Q&A. If you are using a speakerphone, put the phone on MUTE for the best sound quality. If you want to ask a live question:

- Be sure to UNMUTE your phone before you are called on so there is not a pause in the conference, and so the moderator does not pass you over for the next question.
- Lift the handset while asking your question for best sound quality.
- Be sure there are no loud background noises in the room while asking your question.

Should you have questions or concerns, please call 800-424-3688.

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Speaker Bios and Contact Information

Jon Fortune, Ed. D., is a Senior Policy Specialist at HSRI. He received his doctorate from the University of Northern Colorado. Dr. Fortune has solid research skills as well as hands-on experience as a state administrator. In 1990, he joined the Wyoming Department of Health Developmental Disabilities Division where he has held senior management positions. He was instrumental in designing and implementing Wyoming's system of community services for people with developmental disabilities and acquired brain injury, including developing Medicaid HCBS waivers for both populations. During his tenure in Wyoming, the state substantially reduced the number of people served in its large state facility and built an especially strong system of quality community supports. Dr. Fortune was also the chief architect of the precedent-setting Wyoming DOORS model through which people with disabilities are assigned individual budgets based on their assessed needs and other factors. Prior to joining the Wyoming Department of Health, Dr. Fortune managed a community agency in Wyoming and held other positions in Colorado and Illinois and is working on financial architecture in DD statewide services systems in ten states.

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John Agosta, Ph.D. is Vice President of HSRI. He completed his doctorate in Rehabilitation Research at the University of Oregon, specializing in research methods and community supports for people with disabilities. Employed at HSRI since 1983, he has been involved with nearly all efforts at HSRI surrounding family support issues, facilitated development of strategic plans, conducted analyses of state systems for people with developmental disabilities (e.g., Arkansas, Florida, Illinois, Idaho, Oregon, Hawaii, and Texas), and has studied specific facets of the field (e.g., trends in supported employment, managed care, self-determination). He is a nationally recognized expert in topic areas such as family support, self-directed supports and community systems regarding policies that affect individuals with developmental disabilities. He leads the project at HSRI called Sage Resources Person Centered Funding, (www.sageresources.org). This effort concentrates on assessment informed person centered adult waiver reimbursement techniques.

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Bruce Appelgren (Moderator) is Director of Publications for the American Association on Intellectual and Developmental Disabilities. He has published books, manuals, magazines, and commercial newsletters. He is cofounder and former associate publisher of *Health Affairs*, the policy journal of the health sphere.

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Using the SIS to Assess Individual Support Needs and to Develop Person-Centered Funding Models:

System Trends and Challenges, Strategic Overview and Selected Results

June 2009

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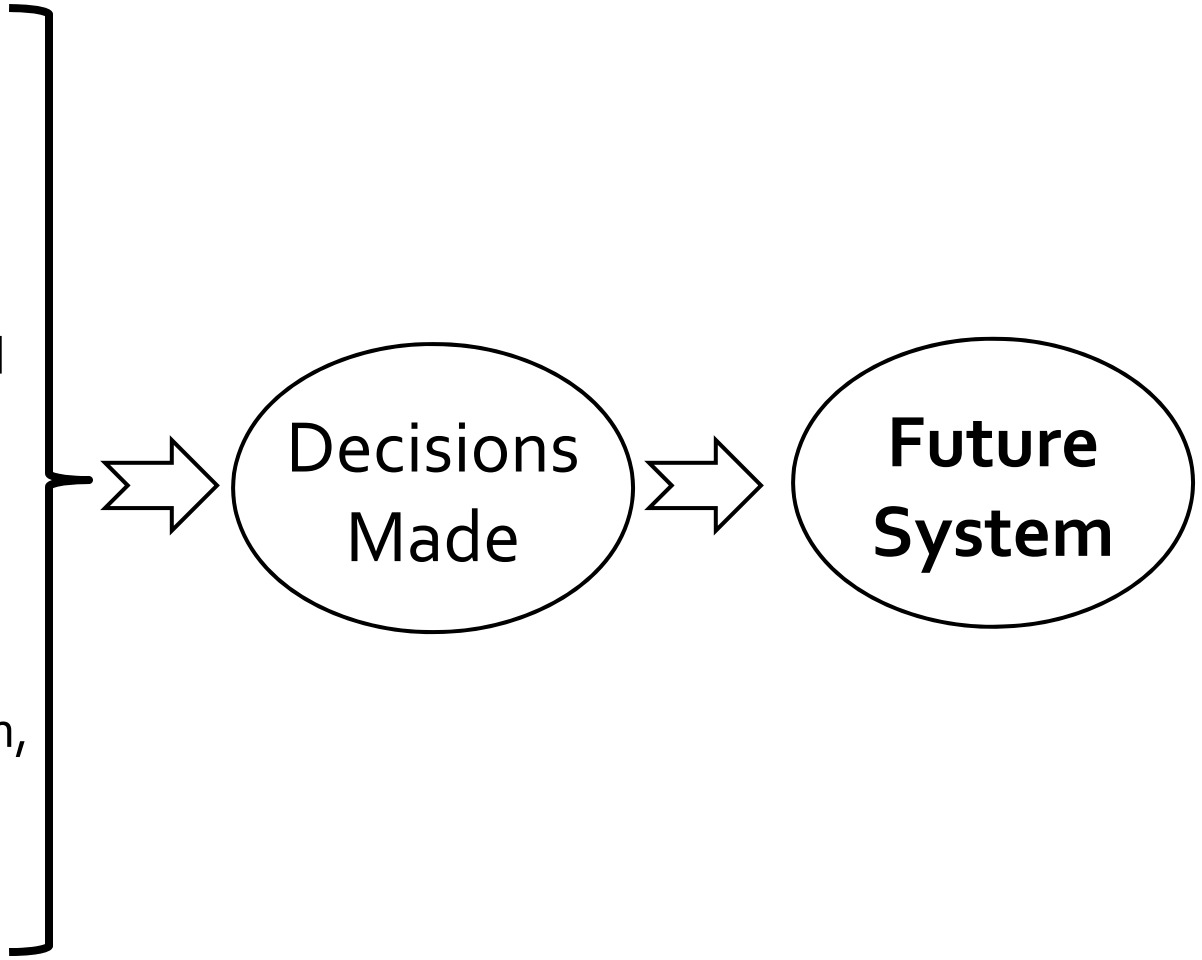
Today's Topics…

- The national context and challenges affecting service delivery
- Focus on developing more efficient & equitable individually tailored resource allocation models
  - The strategic planning process we use
  - The Supports Intensity Scale (SIS) and how it is being used
- Selected findings and analysis from various states
- Your questions

Challenges Faced By Policy Makers…

- Budget stress
- Accelerating service demand
- Reliance on legacy and inefficient systems
- Workforce shortages
- Continued push for community integration, participation, contribution… self direction.



State	Total Budget Shortfall for FY2009	Gap as Percent of FY2009 General Fund	State	Total Budget Shortfall for FY2009	Gap as Percent of FY2009 General Fund
Alabama	$1.2 billion	15.00%	Mississippi1	$114 million	2.20%
Arizona1	$3.1 billion	30.80%	Missouri	$342 million	3.80%
Arkansas	$107 million	2.40%	Nevada	$1.4 billion	19.60%
California	$30.6 billion	30.30%	New Hampshire	$250 million	8.00%
Colorado	$99 million	1.30%	New Jersey	$3.7 billion	11.40%
Connecticut	$542 million	3.20%	New Mexico	$253 million	4.20%
Delaware	$369 million	10.10%	New York	$6.4 billion	11.40%
D.C.	$227 million	3.60%	North Carolina	$800 million	3.70%
Florida	$5.5 billion	21.50%	Ohio	$1.9 billion	6.80%
Georgia	$2.7 billion	12.90%	Oklahoma	$114 million	1.70%
Hawaii	$232 million	4.00%	Oregon	$142 million	2.10%
Idaho	$131 million	4.40%	Pennsylvania	$565 million	2.00%
Illinois	$3.8 billion	13.40%	Rhode Island	$802 million	24.50%
Iowa	$350 million	5.50%	South Carolina	$804 million	11.70%
Kansas	$137 million	2.10%	South Dakota	$27 million	2.20%
Kentucky	$722 million	7.80%	Tennessee	$1.2 billion	10.40%
Maine	$265 million	8.60%	Utah	$354 million	5.90%
Maryland	$1.3 billion	8.80%	Vermont	$122 million	10.00%
Mass.	$2.6 billion	9.20%	Virginia	$2.2 billion	12.80%
Michigan	$472 million	4.80%	Washington	$413 million	2.70%
Minnesota	$ 1.4 billion	7.90%	Wisconsin	$998 million	7.10%

Texas projects budget gaps in FY2010

Total Shortfall $78 billion …

This was reported just after the October economic downturn

McNichol & Lav, Center on Budget and Policy Priorities, 2008

Service Demand Is Going Up!

- Demand for publicly-funded developmental disabilities services is growing nationwide
- It is increasing at a rate greater than population growth alone
- This increase in service demand is driven by:
  - People living longer … or surviving trauma
  - Aging baby boomers

➢ Turnover among individuals receiving services is reduced so that there is less capacity to absorb new demand

➢ There is a growing number of individuals who live in households with primary caregivers who are themselves aging

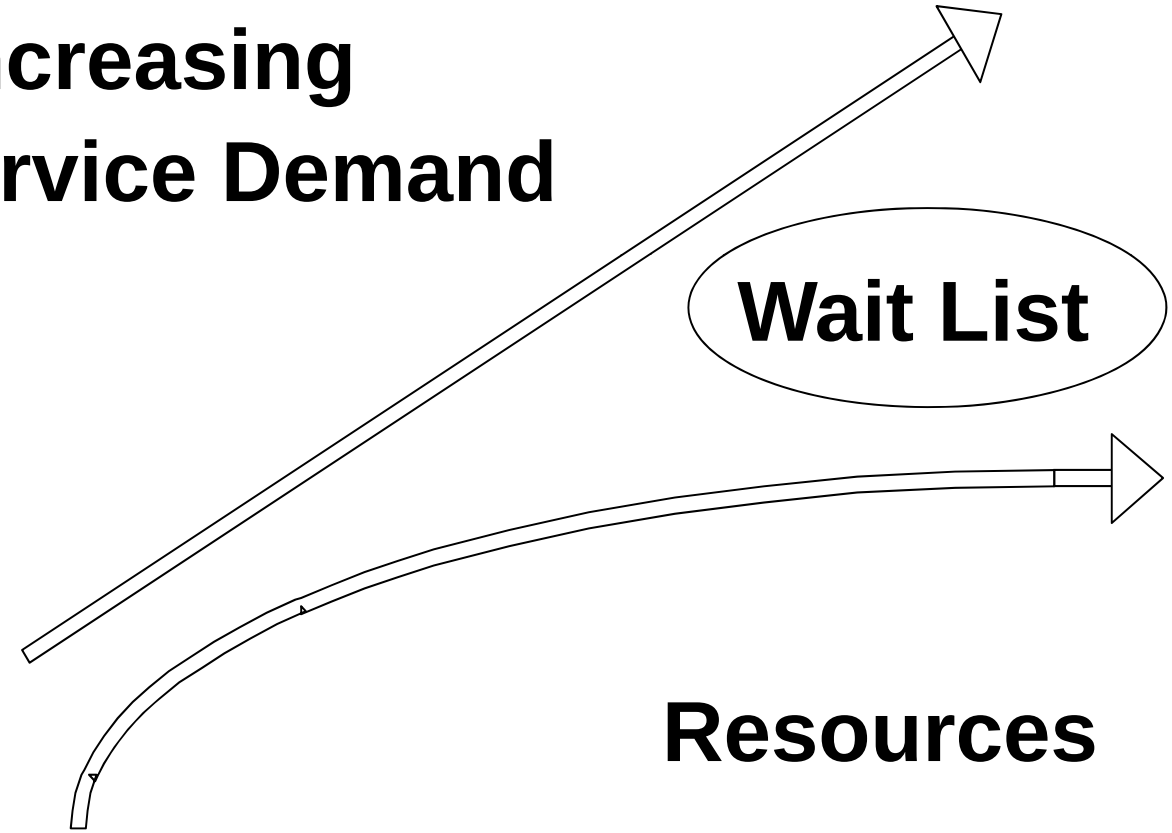
Waiting for Residential Services

People Waiting	Residential Services Recipients	% of Growth Needed
88,349	437,707	20%

People with ID/DD on a waiting List for, but not receiving, residential services on June 30, 2007

Prouty, R., Smith, G. and Lakin, K.C. (eds.) (2008). *Residential Services for People with Developmental Disabilities: Status and Trends Though 2007*

States Face a Big Problem…



Gary Smith, HSRI

Reliance on Legacy Systems…
It's A Living Museum …
Can this be efficient?

Sheltered Work

Customized Employment

Day Habilitation

Group Homes

IEP, ISP, IHP, IWRP, IFSP, IPP

Family Support

Token Economies

Apartments

Public Institutions

Supported Living

Supported Work

ICFs-MR

Self-determination

1956... 1962... 1972 ... !976...1983... 1987.. .1992... 1997.. 2000... 2003…2008

Work Force Shortages Are Real

- Providers have trouble hiring and keeping staff.
- Families have trouble hiring respite workers.
- Pay is low. Benefits are not always the greatest.
- There are often issues to overcome related to culture and staff.
- We imagine systems that are well staffed by well trained people.
- We compensate with a mountain of rules, pre-scripted routines and paperwork.

He's broke. Must be a direct support worker…

Hear Self-Advocates

People want to live the life they want in the community with the support they need. Just like anyone else.

Heading for a crash!

Weighty Legacy Services & Structures

Rising Unmet Demand

Workforce Shortages

Fragmentation

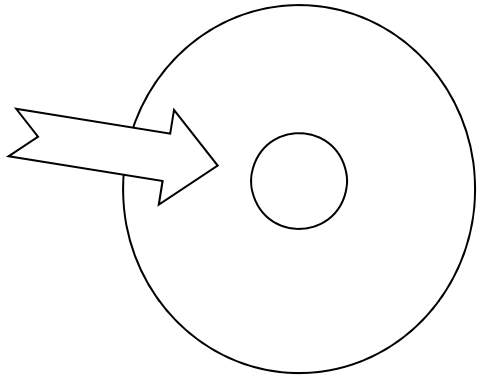
Quality Problems

Antiquated Technologies

Budget Shortfalls

What To Do?

We can't stay on this spot



We need to rethink what we do – affirm our values but resolutely search for "value"

Things Have and Are Changing…

This ain’t the same system it was ten years ago!

Sustainable Futures …

*An action agenda anchored in **values** and committed to making the **changes** necessary to secure the best **outcomes** possible for people with developmental disabilities and families.*

We Must Make Our Service Systems More Efficient & equitable

- Reform our person-centered system architecture
- Disinvest from low value/high cost services
- Utilize Medicaid Efficiently!
- New business models… Open markets
- "Non-traditional" providers/direct purchase of supports

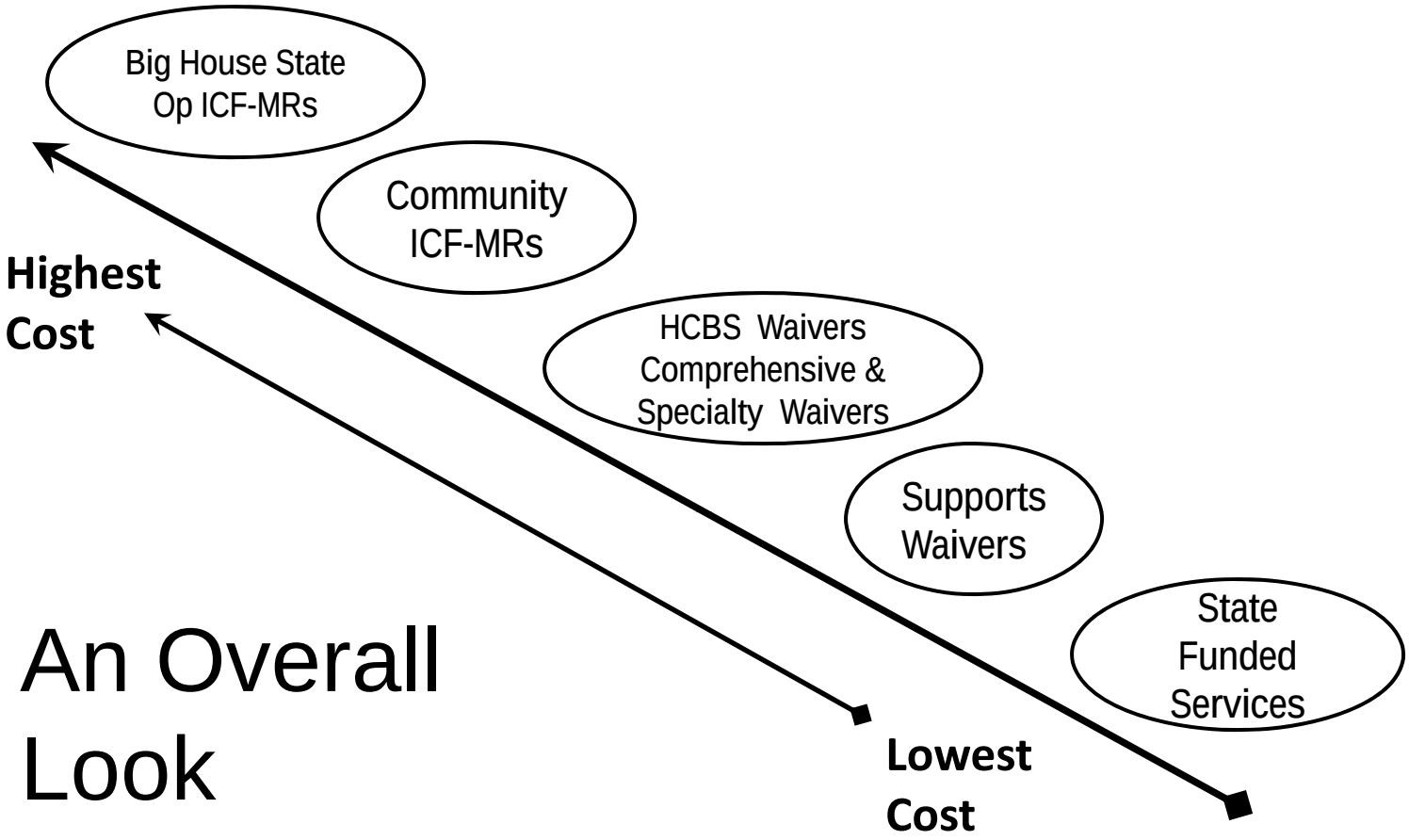
Efficiency & Equity

Efficiency gains come from understanding exactly what it costs to provide a service at a given level of quality for a particular type of person. Most state developmental disability agencies, however, know little about per person actual costs.

Equity requires understanding what supports individuals need, and a fair allocation of resources to address personal needs.

Few systems have assessment processes that translate directly into resource allocations. Over time decisions made about expenditures often appear idiosyncratic and unfair.

An Overall Look at Things



⇧ ⇧ ⇧ ⇧ DEMAND

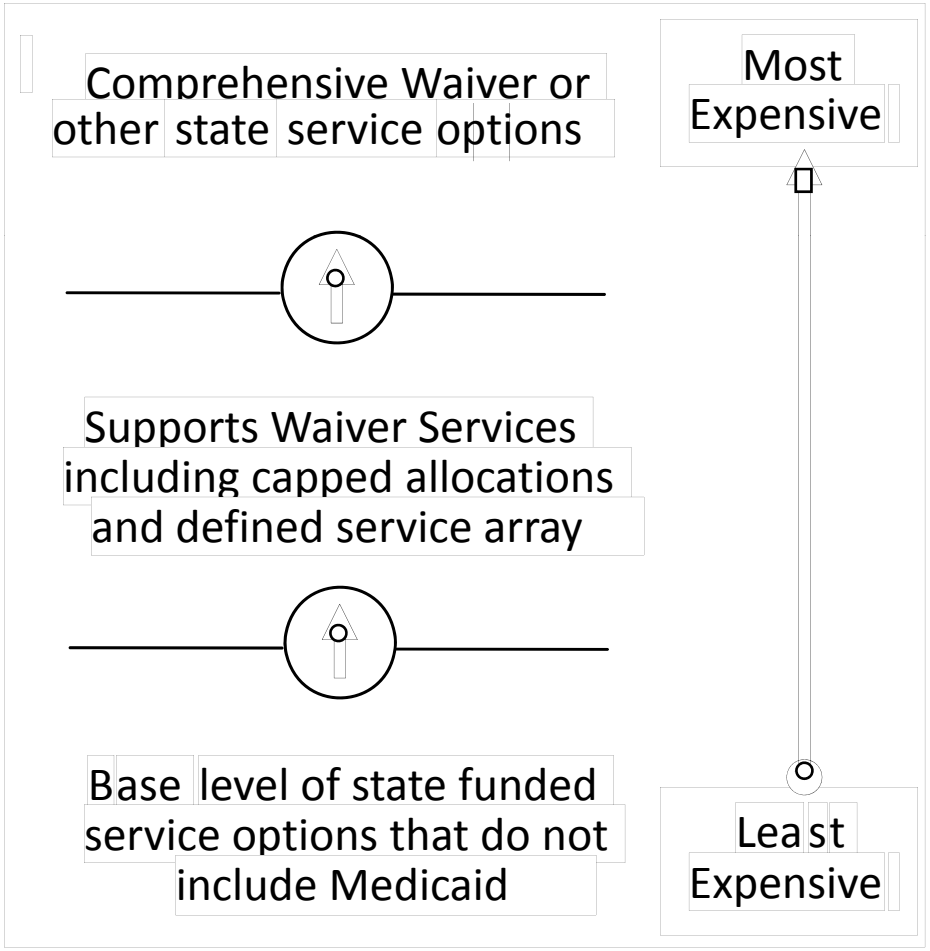
About 4% more per year

People with Developmental Disabilities (1% of the population)

We've Already Taken Some First Steps

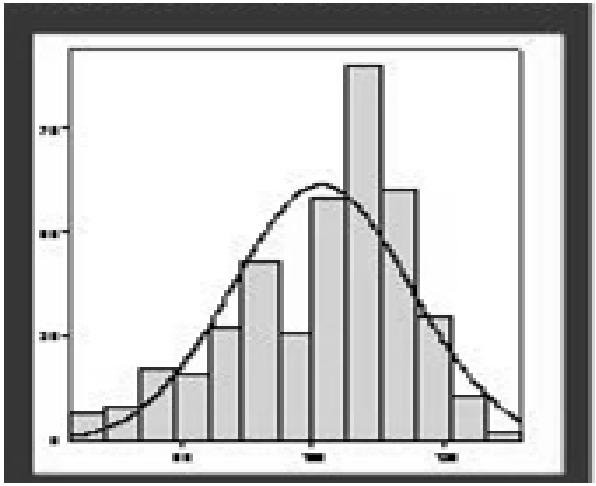
- Fewer that 40,000 in institutions; 10 states with no institutions
- Residential options are getting smaller
- ICF-MR/DDs are "out"; Waiver services are "in"
- States are investing in "in-home supports" through supports waivers
- **States are looking at how to allocate resources to individuals**

HCBS Waivers Working Together



Working To Get Personal Allocations Right

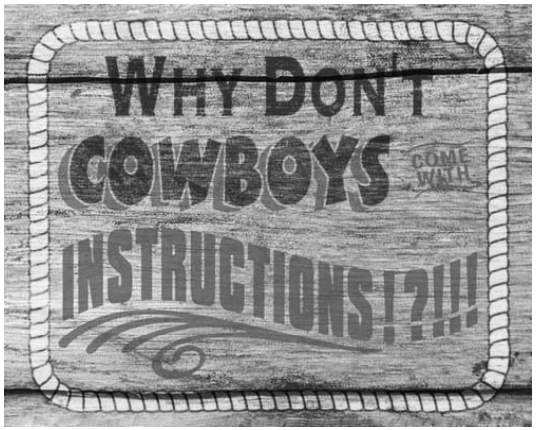
- Do we really know what it costs to serve a person?
- Why are some people allocated more that others, even though they have similar needs?
- Is the way we allocate funds fair? Is it based on support needs?
- Is this efficient?
- Several states are working to assess needs systematically and allocate accordingly



Person-Centered Budget Allocations

Adjusted Service Reimbursement Rates

Focus on Developing Resource Allocation Models

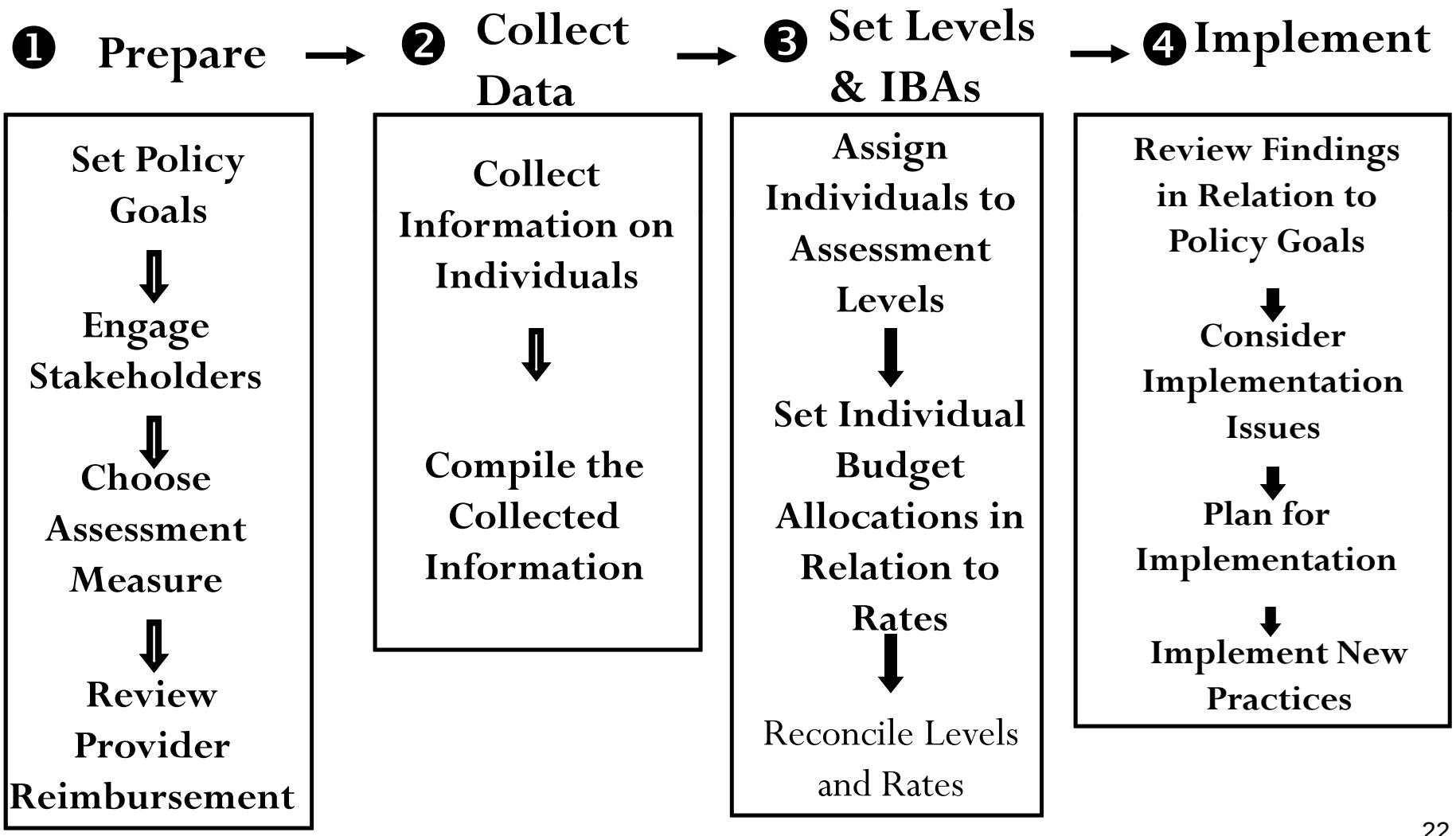


SIX Assumptions:

1. Individual people have needs.
2. Individuals with greater needs should have access to more resources.
3. No two people have the same needs, supports and priorities.
4. Individuals and their teams know best.
5. People should choose providers.
6. It is possible to make it happen.

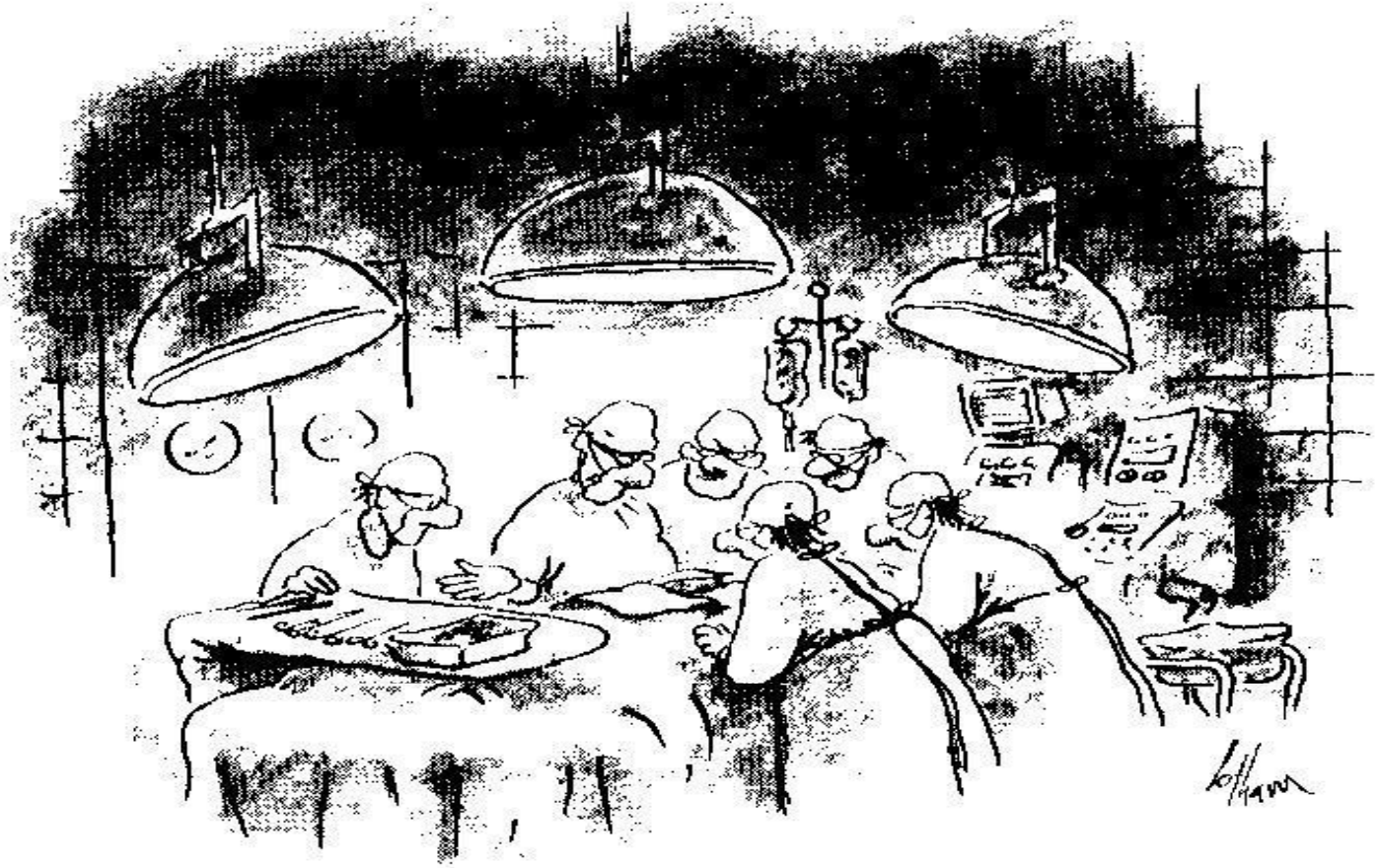
Overview of the Strategic Planning Process

Developing Individual Budgets In Relation to Service Payment Rates



HCBS waiver reimbursement is not rocket science. It is a lot harder.

Gary Smith

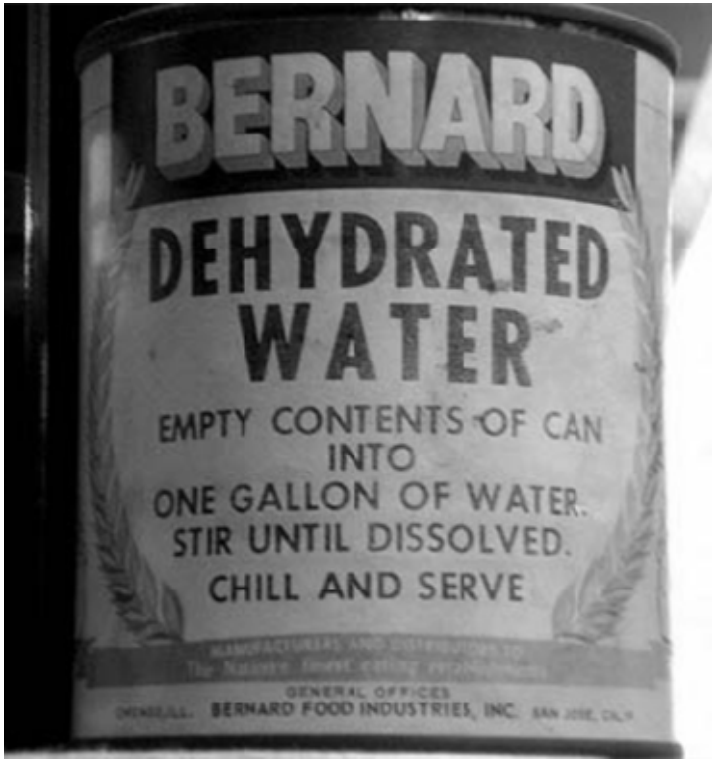


"Let's just start cutting and see what happens."

The ETERNAL QUESTION:

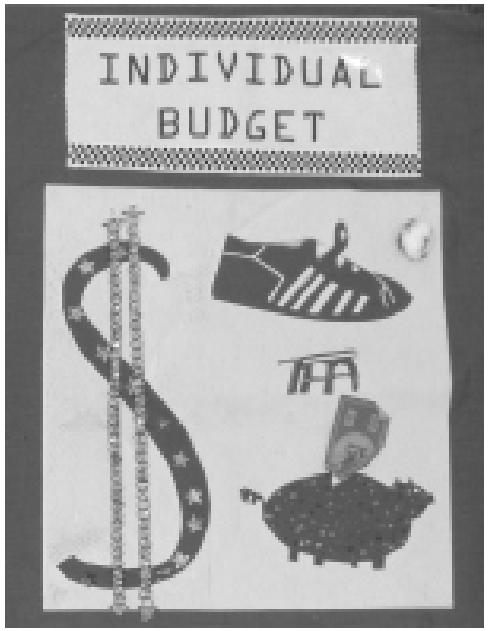
How do we deliver what we <u>have</u> to the people who <u>need</u> it most ?

Robert T. Clabby, II Oregon



Defining *Individual Budget Allocations*

Given that the field is moving toward individualized budgets, it is essential for policy makers to be precise in what is meant by an "individual budget allocation" (IBA).



- Dollar amount tied to needs, total budget
- Individual decides how to use the full amount
- New budget is prospective rather than retrospective

“It’s impossible to individualize service until you’ve individualized the funding.”

Russ Pittsley

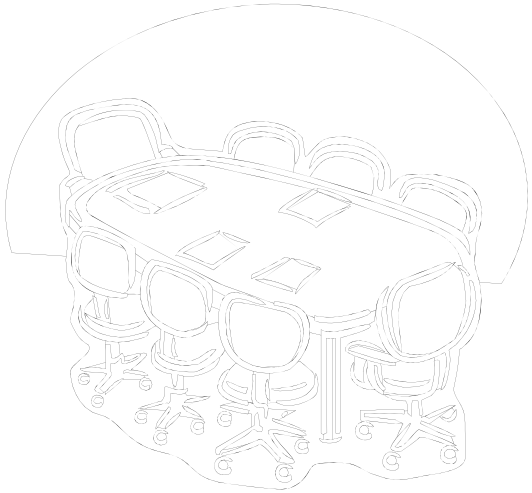
Step 1. Prepare

Potential Policy Goals

- Fairness, equitability, explicability
- Increase efficiency to address increasing demand
- Matching resources and individual needs
- Ability to handle exceptional care
- In a time of limited resources - focus on those with greatest need
- Inject self-directed approaches

Step 1. Prepare

Stakeholder Involvement



A stakeholder group should be formed:

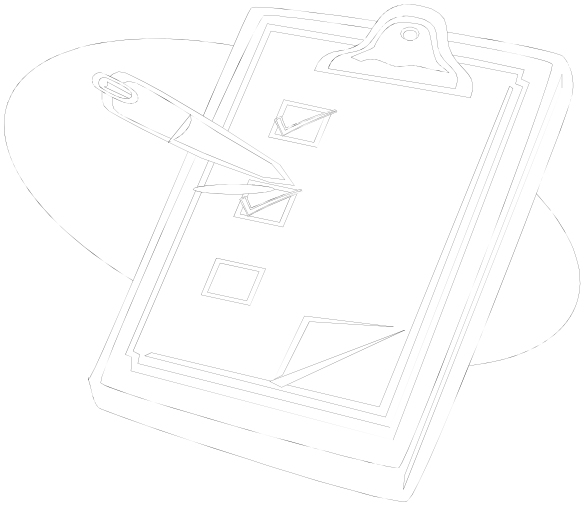
- To help advise the process
- To assure that people know what the process is finding and what decisions are being made.

The stakeholder group should meet regularly and be composed of self-advocates, parents, providers, and others.

Step 1. Prepare

Choose an Assessment Tool

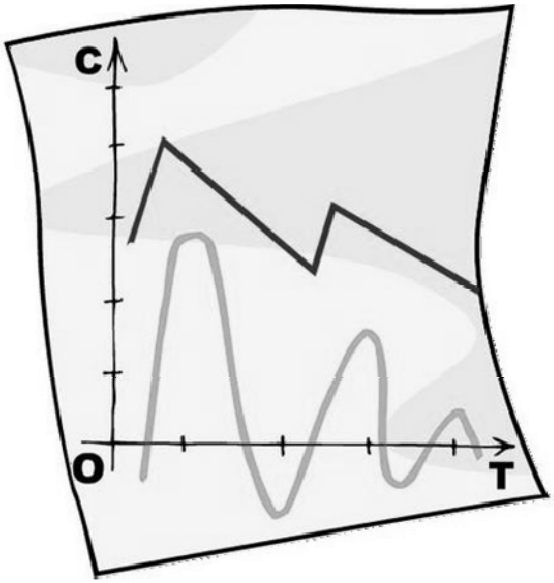
- Assessment tools provide information about support needs
- States use various tools to tie funding to support needs
- Each tool has its pros and cons



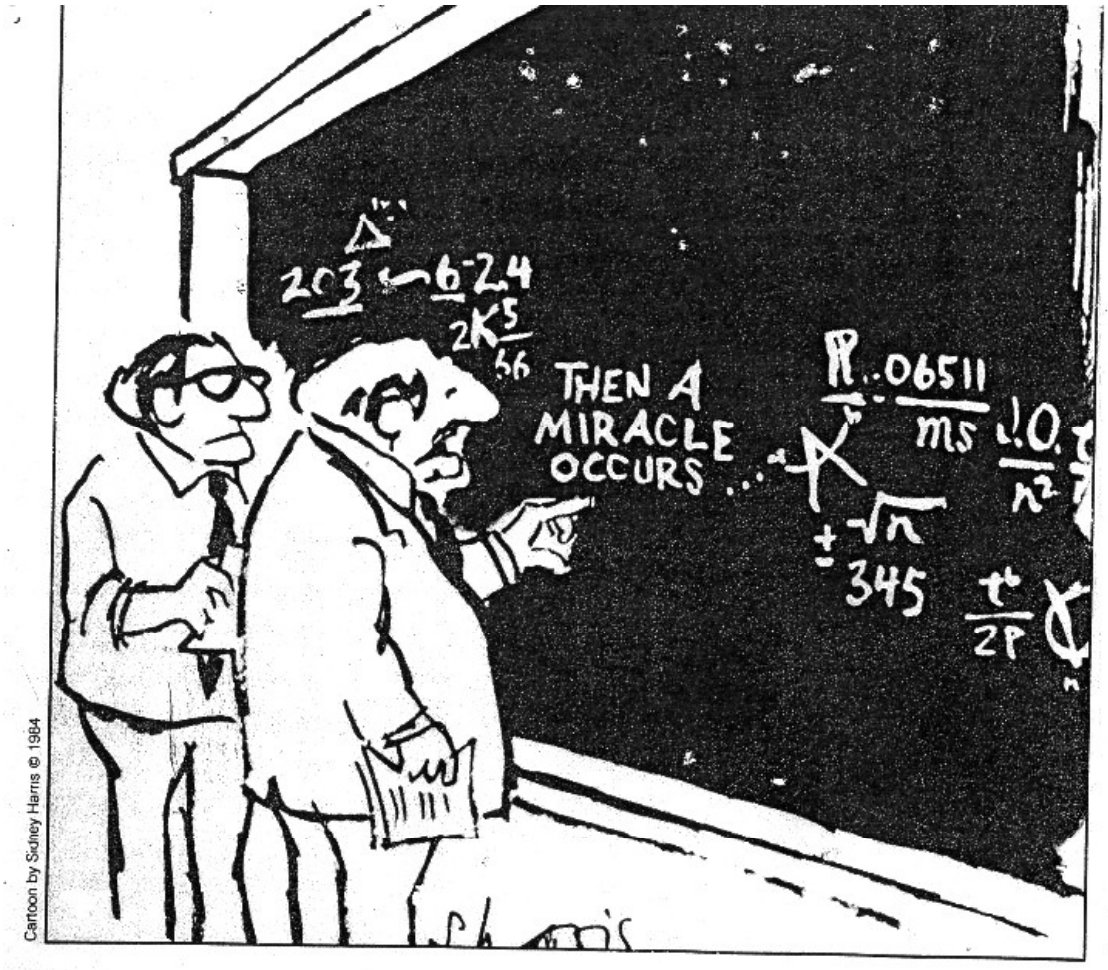
Step 2. Collect & Compile Information

Data Data Data

- A good database is invaluable…
- Many factors explain variance
- All the predictors work together as a team
- The techniques are often powerful enough to be able to overcome minor error and work well
- Allocations and plans are based on the "FOUR Ps"… Personal, portable, prioritized, predictable



Step 3. Setting Individual Budget Allocations and Adjusting Rates



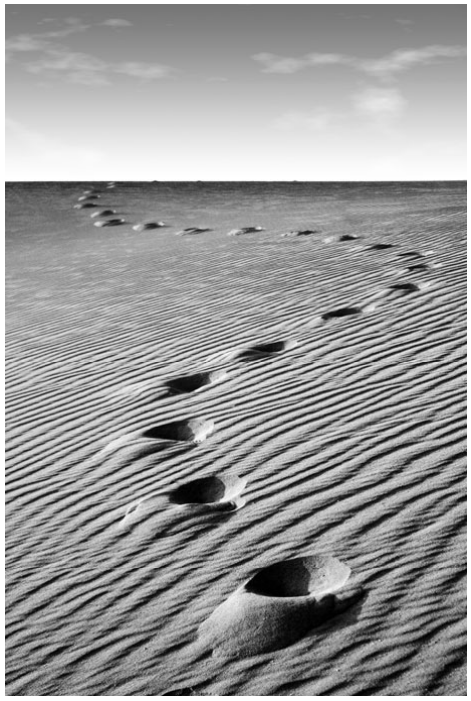
"I think you should be more explicit here in step two."

Step 3. Setting Individual Budget Allocations/Adjusting Rates

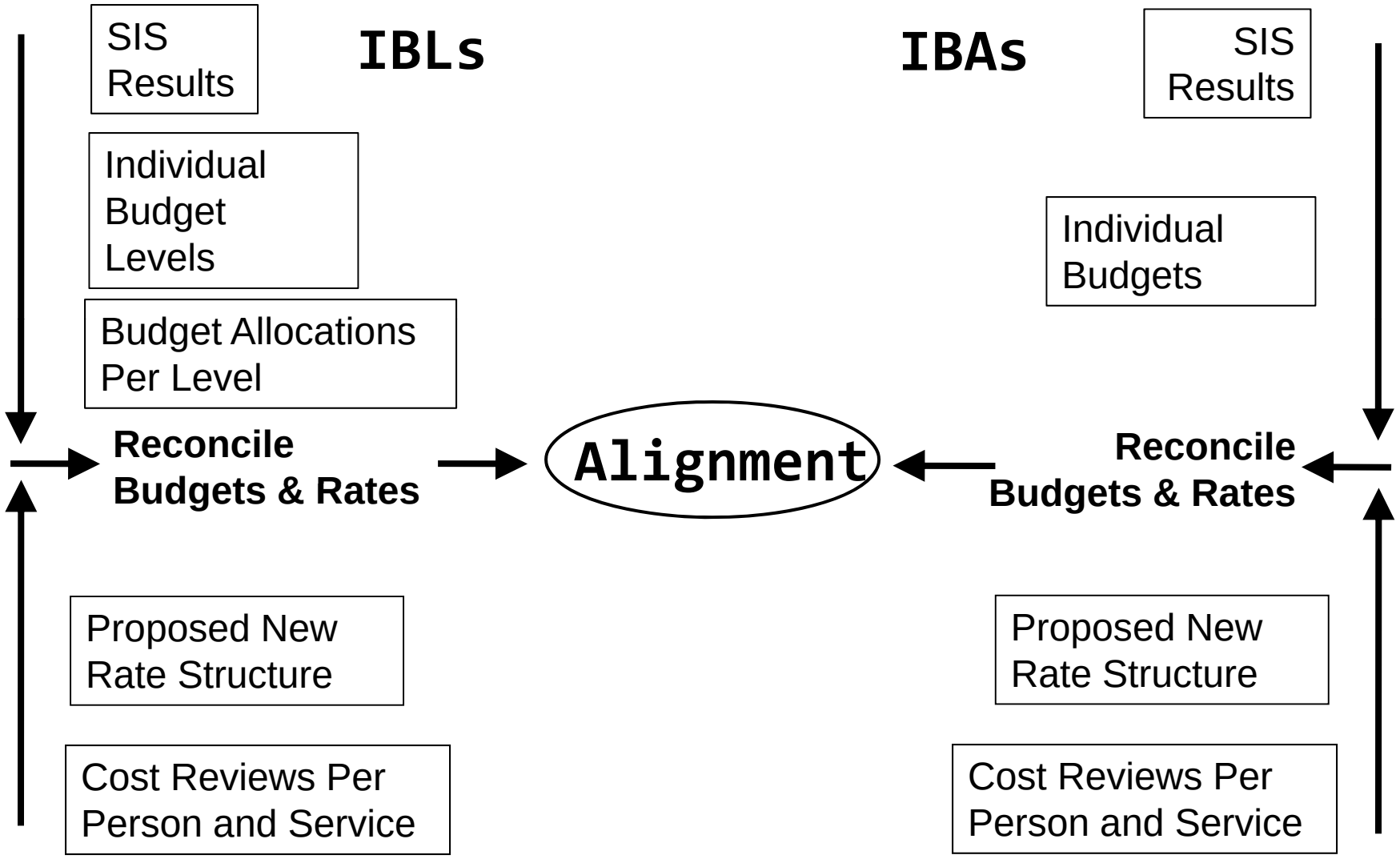
Several steps in the process

- Determine what variables correlate highest with expenditures;
- Given analysis of support needs and the support they receive …
  - Individuals are assigned to an "**Individual Budget Level**"

    -- OR --
  - Individuals are given their own unique "**Individual Budget Allocation**;"
- A "best fit model" is built to align individuals and their needs with budget allocations;
- These findings are reconciled with the rates associated with payments to service providers.



Step 3. Setting Individual Budget Allocations/Adjusting Rates



Step 3. Setting Individual Budget Allocations/Adjusting Rates

Questions to be answered…

Retrospective versus prospective budgeting?

- Most states have moved to the prospective method where the team and individual knows their individual budget prior to the individual service plan development.
- Some form individual budgets after the individual service plan is developed.
- CMS offers individual budget definition:

Step 3. Setting Individual Budget Allocations/Adjusting Rates

The HSRI approach to setting Individual Budget Allocations

- Spread people out based on their support needs and resource consumption patterns.
- Each person will have his or her own unique personal budget or budget level.
- In observing the spread their should be:
  - Face validity
  - A logical progression from least to most needs
- Account for all those assessed.

Step 3. Setting Individual Budget Allocations/Adjusting Rates

The HSRI approach to assigning individuals to individual budgets or budget levels:

- Identify people with similar characteristics.
- Group these individuals based on resource consumption patterns.
- Develop budget levels or individual budgets in ways to :
  - Establish face validity
  - Have a logical progression from least to most needs
- Check the progression in the number of people per category… ideally the most people populate the budget levels indicating less need.
- Account for all those assessed
- Establish separation between budget levels (hours and/or costs)

We are looking for a "Best Fit Solution"

Step 3. Setting Individual Budget Allocations/Adjusting Rates

Questions to be answered…

What does CMS require of individual budgets?

- States must describe the method for calculating individual budgets based on reliable costs or services utilization.

  By 2007 ten states have recently engaged in waiver cost studies to determine cost-based reimbursement for waivers (i.e., IL, WY, OR, FL, MA, OH, FL, MT, WA).

  (Reinhard, Crisp, Bemis, and Huhtala, 2005)

Step 3. Setting Individual Budget Allocations/Adjusting Rates

Questions to be answered…

What does CMS require of individual budgets?

- Cost and utilization data should form the vital underpinnings of good individual budget development.
- Consistent methodology should be used for all involved participants, and individual budgets should be reviewed regularly.

Step 3. Setting Individual Budget Allocations/Adjusting Rates

Questions to be answered…

What does CMS require if individual budgets?

- From the perspective of consumers and advocates, a viable methodology should:
  - be open to public inspection,
  - allow the participant to move money around, and
  - define a process for making adjustments in the individual budgets and for informing participants of amount authorized or changes to those authorizations.
- From the perspective of the state, the methodology should:
  - permit the state to evaluate over and under expenditures
  - project system-wide expenditures through the fiscal year.
  - provide prompt mechanisms to adjust funding in response to individual situations.

Step 3. Setting Individual Budget Allocations/Adjusting Rates

Questions to be answered…

What liability does the state face if it cannot fund the individual budgets?

- In the United States the range of funding of DD services varies greatly.
- States generally change the individual budgets to meet their legislatively approved budget.
- Rates for services, though benchmarked for national costs, may be a percentage of the national cost. For example, last year Colorado was paying about 75% of costs in a rate study completed by Navigant Consulting.

Step 3. Setting Individual Budget Allocations/Adjusting Rates

Questions to be answered…

Do these individual budget allocations or individual budget levels ever need adjustment?

- Any reimbursement method requires some way to adjust to changing circumstances and sometimes unfortunate new challenges presented by the individuals we serve.
- Some of the best, highly tuned individual budget systems allow adjustments for exceptional cost and care for 7% of the population served.

Step 3. Setting Individual Budget Allocations/Adjusting Rates

Questions to be answered…

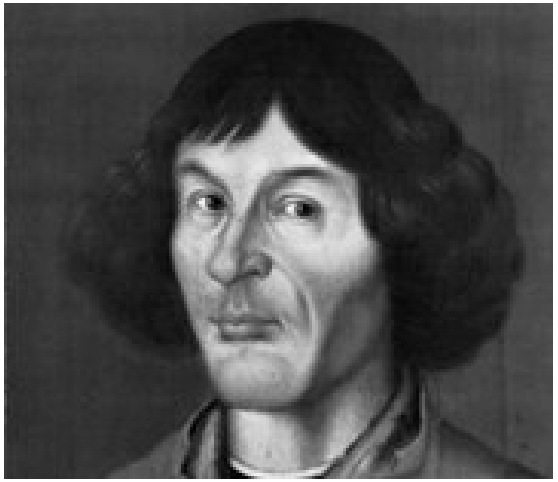
Is there a more objective and rational way to support the service needs of the individuals we serve in communities?

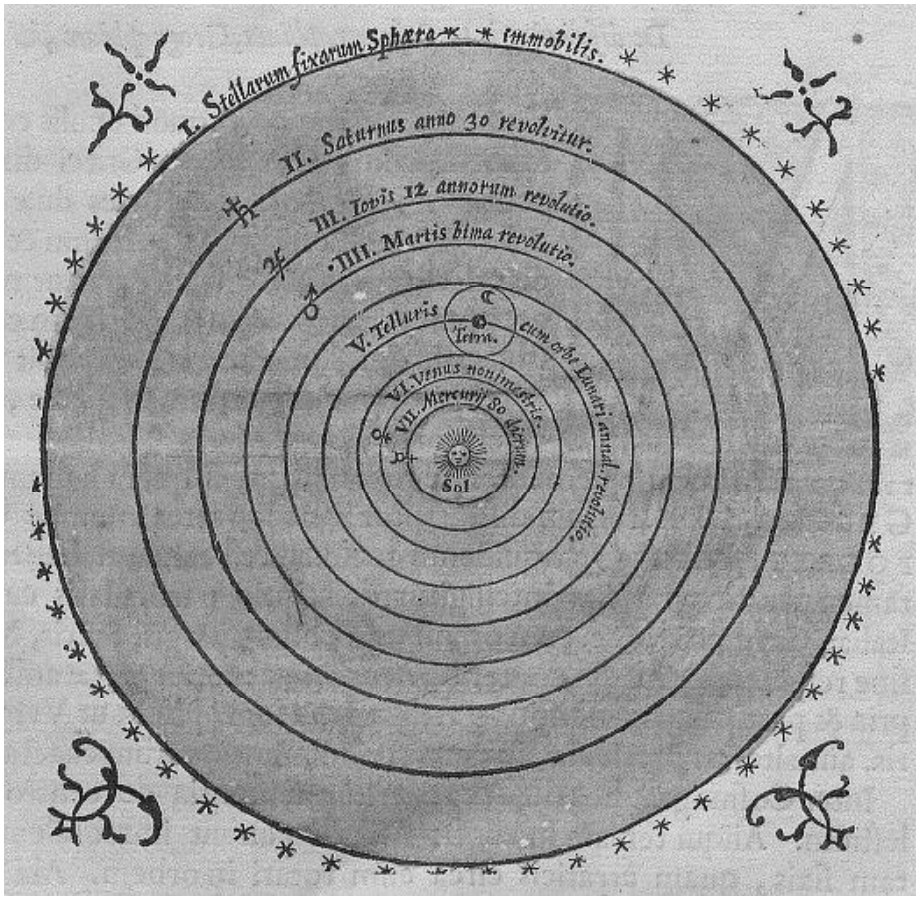
- What is the best way (in a technical sense) to make it work?

Step 4. Implementation

Before a new model is implemented…
Several steps must be completed…

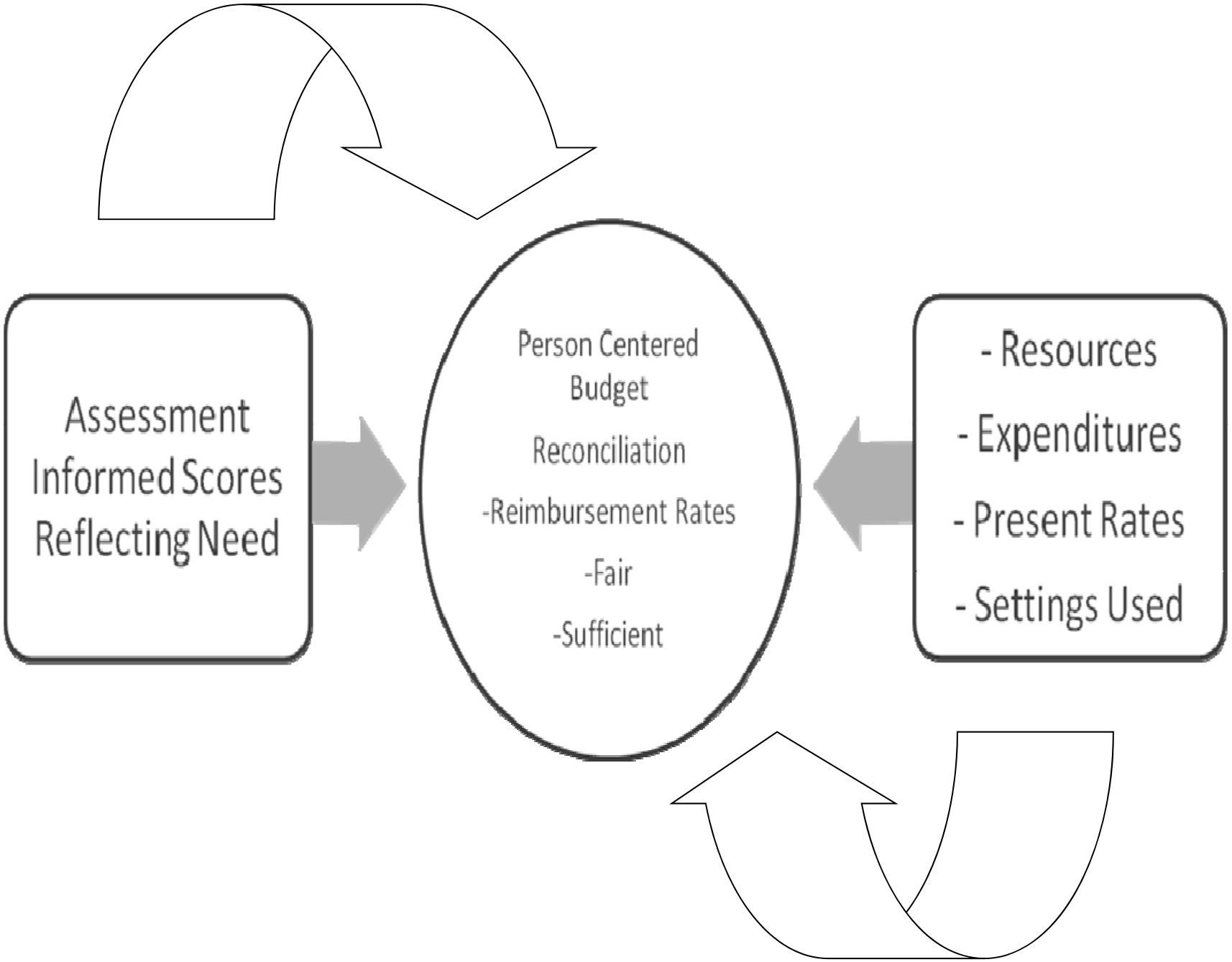
- The findings and proposed models must be considered in relation to initial policy goals.
- Impacts on individuals, providers and the system must be considered.
- An "exceptions protocol" must be developed.
- Potential dislocation in the system must be considered.
- Needs for improved infrastructure must be considered.
- A detailed implementation plan must be compiled, and then enacted.



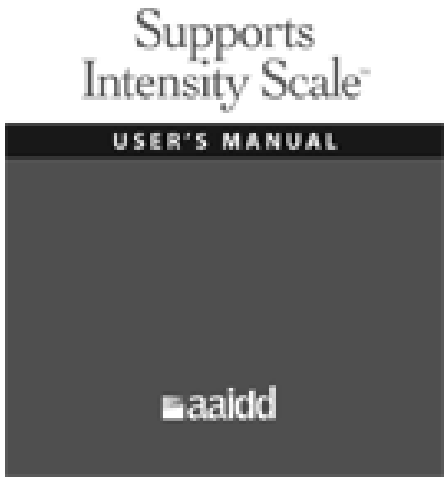


Early models have simple rules but revolutionary concepts

HSRI is designing the financial architecture for DD/ID service systems


Assessment Informed Scores Reflecting Need
Person Centered Budget
Reconciliation
-Reimbursement Rates
-Fair
-Sufficient
- Resources
- Expenditures
- Present Rates
- Settings Used

The Supports Intensity Scale (SIS) and how it is being used



What is the SIS?

- Developed and released by AAMR in 2004
- Originally designed to support person-centered planning, not funding
- Only adult version available – child version is under development
- Currently 14 states and 14 countries using SIS
- Perceived as strength-based
- Must be purchased/licensed from AAIDD

Supports Intensity Scale

- Administration: Interview the person and others who know the person. Requires solid interviewing skills
- Measures general support needs of an individual producing a number of scores
- Includes basic support need areas like:
  - A. Home Living Activities,
  - B. Community Living Activities, and
  - E. Health and Safety Activities
  - SIS ABE – refers to the sum of the scores for these 3 areas that have been found useful in helping resource allocation
- Identifies Medical and Behavior problems which are also significant cost predictors


Supports Intensity Scale

Interview and Profile Form

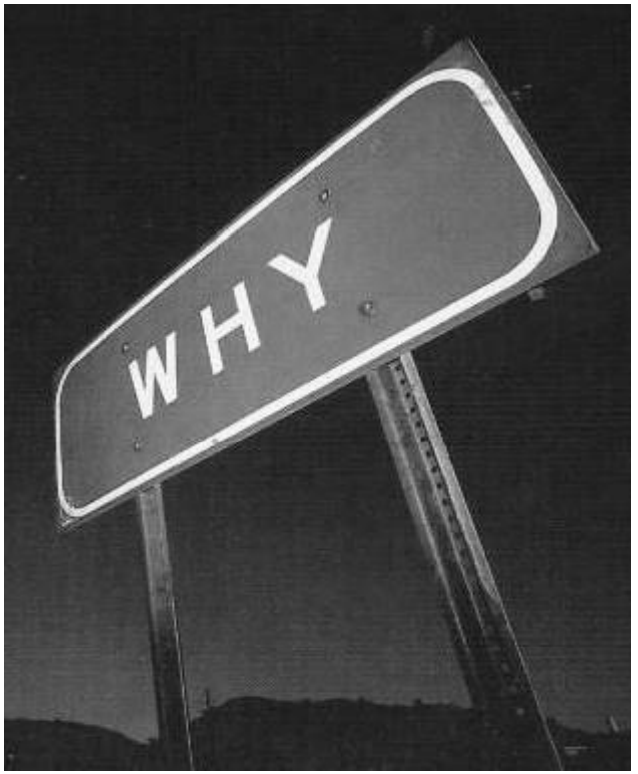
AAMR

SIS and Funding Models

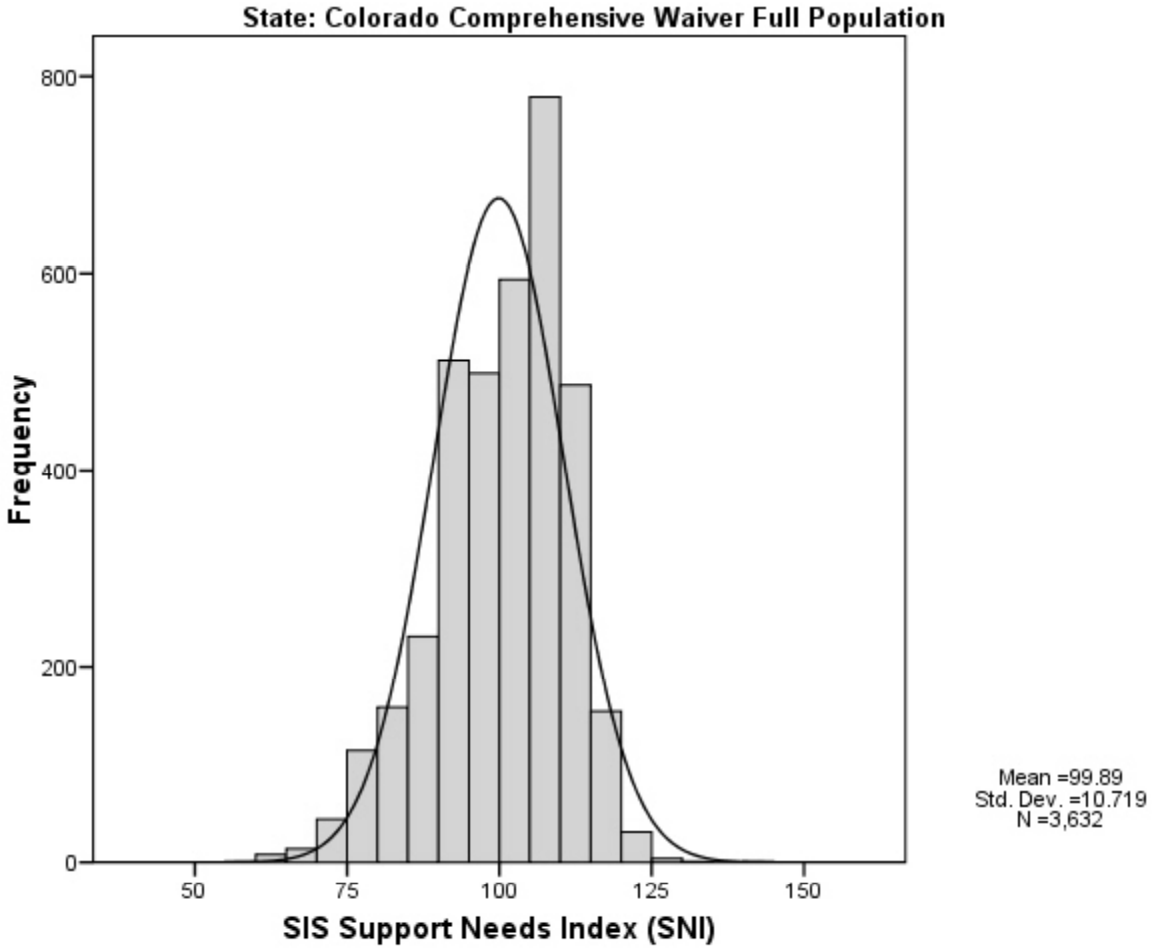
- Georgia - using the SIS to develop individual budget allocations for 10,522 people beginning October 2008 for their new support and comprehensive waivers
- Washington: Linking SIS and other information to levels of payments and amounts of support services
- Louisiana: informally using a SIS-informed funding system with 2,025 new NOW waiver applicants beginning in January 2009
- Hawaii, Rhode Island, North Carolina, and Utah are exploring SIS applications
- Oregon and Colorado are using SIS to inform the development of funding reimbursement models
- Florida is exploring use of a local state tool, the QSI, to determine support needs and establish levels of funding for 38,000 people in a new four tiered-waivers system designed to contain expanding cost

Why do states pick the Supports Intensity Scale?

- National norms – buying the bell shaped curve
- Writing waiver service plans with individuals, families, and providers
- Captures support needs hence some of the natural supports used by individuals
- Considers both behavioral and medical challenges
- Has potential for helping to shape waiver individual budgets and/or reimbursement levels



“Buying the Bell Shaped Curve”



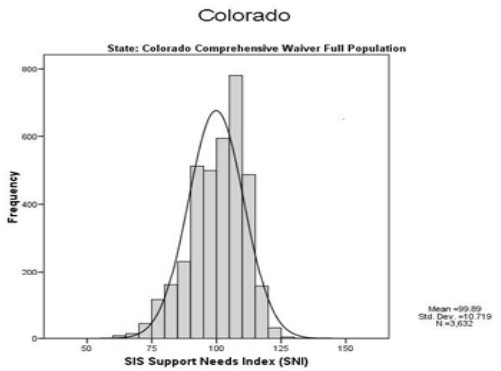
State SIS Comprehensive Adult Waiver Results

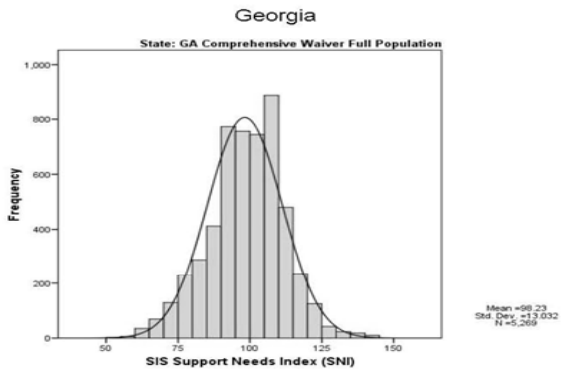
State	People	Total Support Needs Index Score (Range 38-143)	Medical Support Needs (Range 0-32)	Behavioral Support Needs (Range 0-26)
SIS Norms	1,306	100.00	2.47	4.99
OR	401	101.00	3.27	4.98
NE	288	100.42	3.23	4.81
CO	3,631	99.88	2.83	6.13
VA	521	101.74	2.43	4.77
GA	5,206	98.20	1.95	3.79
UT	3,759	100.09	2.29	4.36

Comprehensive HCBS Waiver SIS Results – Similar Shapes

Figure 2: SIS Results in Four States

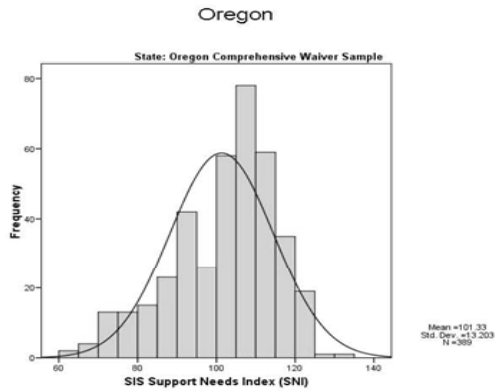
Colorado

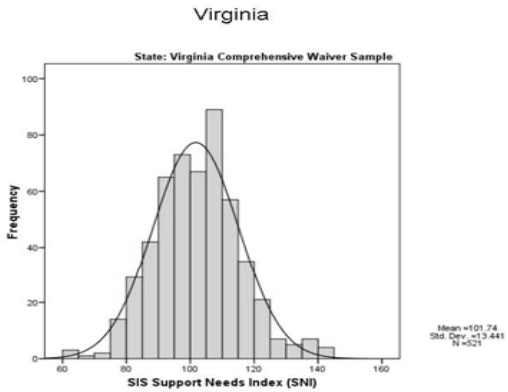




Georgia

Oregon





Virginia

SIS Support Needs Index Scores

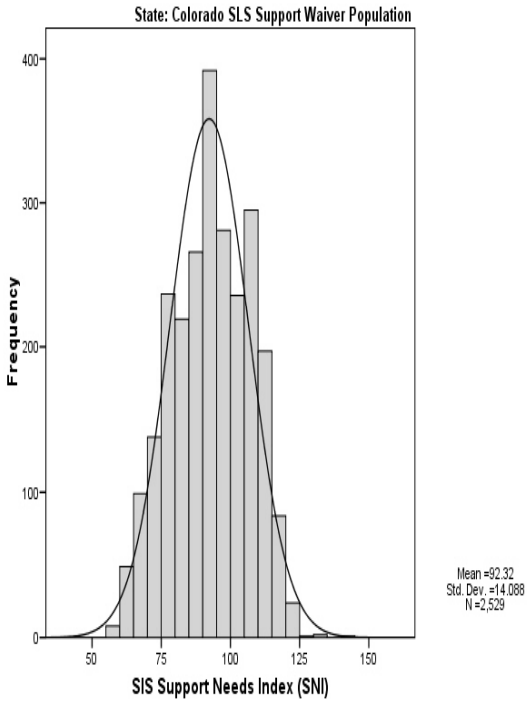
State SIS Support Adult Support Waiver* Results

State	People	Total Support Needs Index Score (Range 38-143)	Medical Support Needs (Range 0-32)	Behavioral Support Needs (Range 0-26)
SIS Norms	1,306	100.00	2.47	4.99
CO SLS	2,530	92.32	2.78	2.93
GA NOW	5,023	90.94	1.26	1.75
LA NOW	443	92.67	1.92	1.90
MO Waivers	2,717	92.14	2.07	3.95

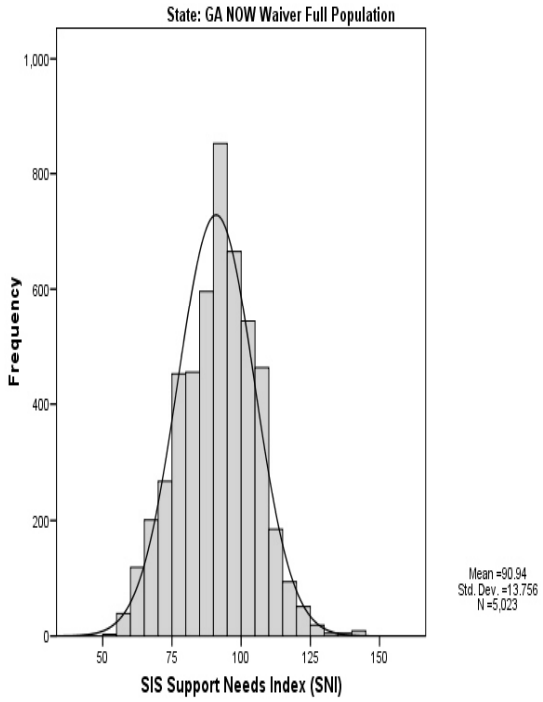
* http://aspe.hhs.gov/daltcp/reports/2007/gaugingfr.htm

HCBS Waiver Support Waivers
SIS Results – Similar Shapes

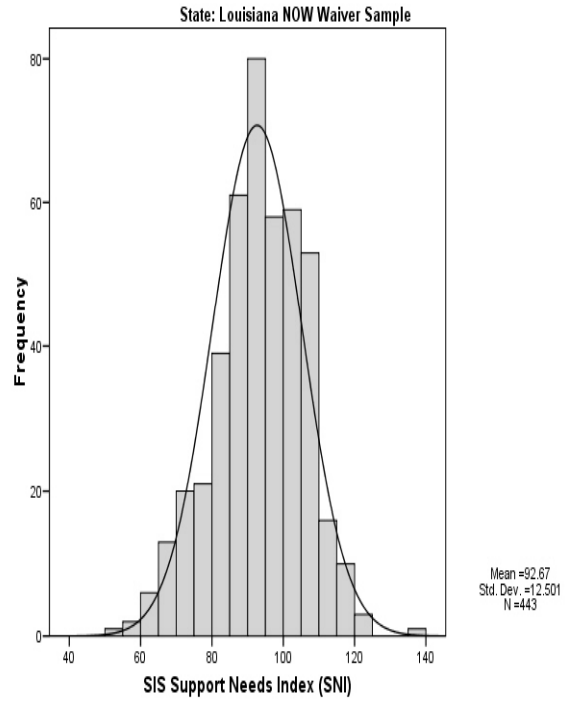
Colorado SLS



Georgia NOW



Louisiana NOW



SIS Support Needs Index Scores

Case Studies -- Working with States

Georgia

Colorado
Oregon

Virginia
Louisiana

If I am only for myself, who is for me?

And if I am only for myself, what am I?

And if not now, when?

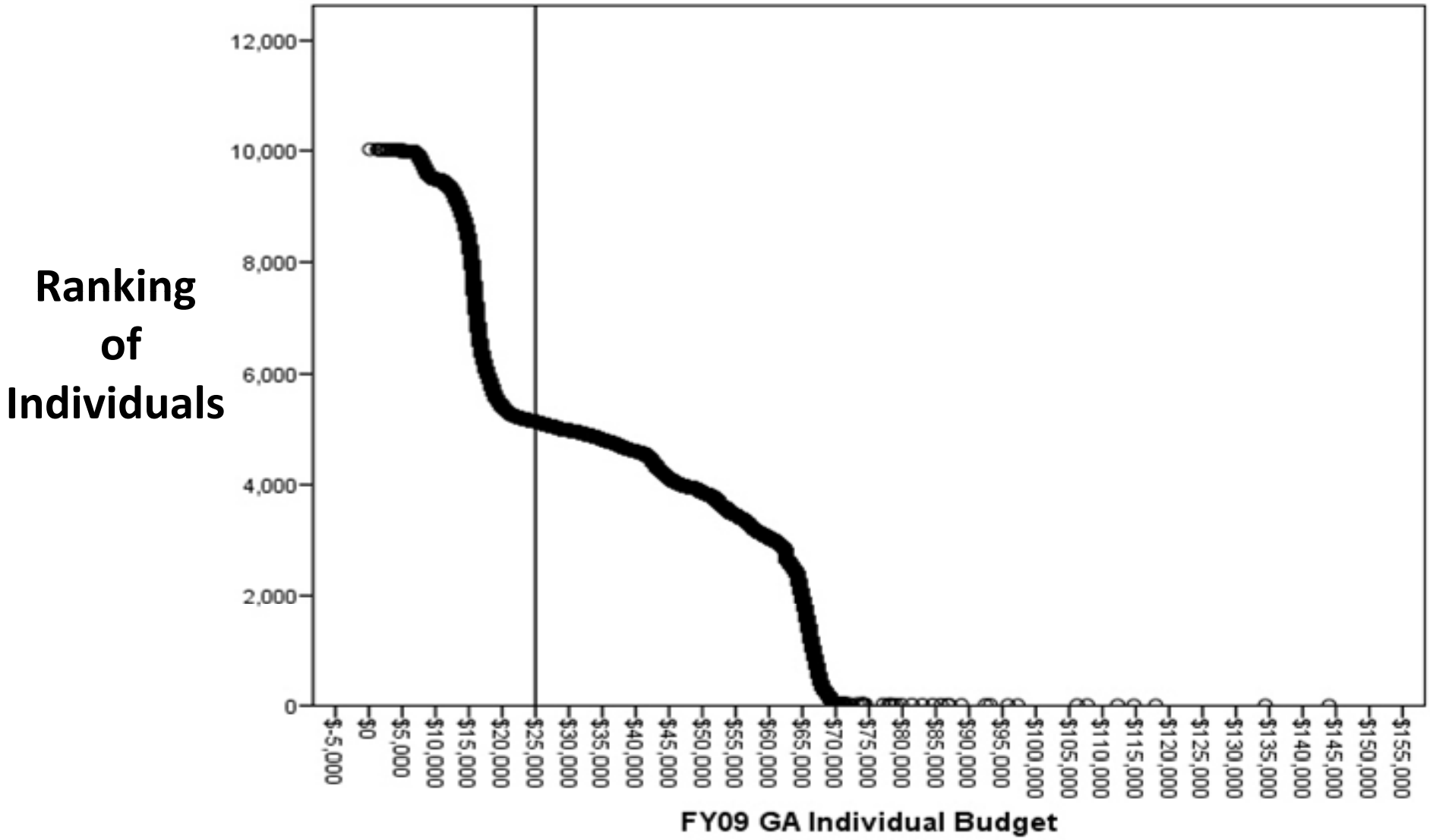
Rabbi Hillel

Georgia Resource Allocation System November 2008

- Uses SIS results to provide individual budgets for 10,527 individuals on the state's new comprehensive and support waivers.
- This individual budget model explains over 75% of the variance and is phased in over 5 years to reduce impacts.

NOW Waiver
N= 4,885

Comprehensive Waiver
N= 5,142



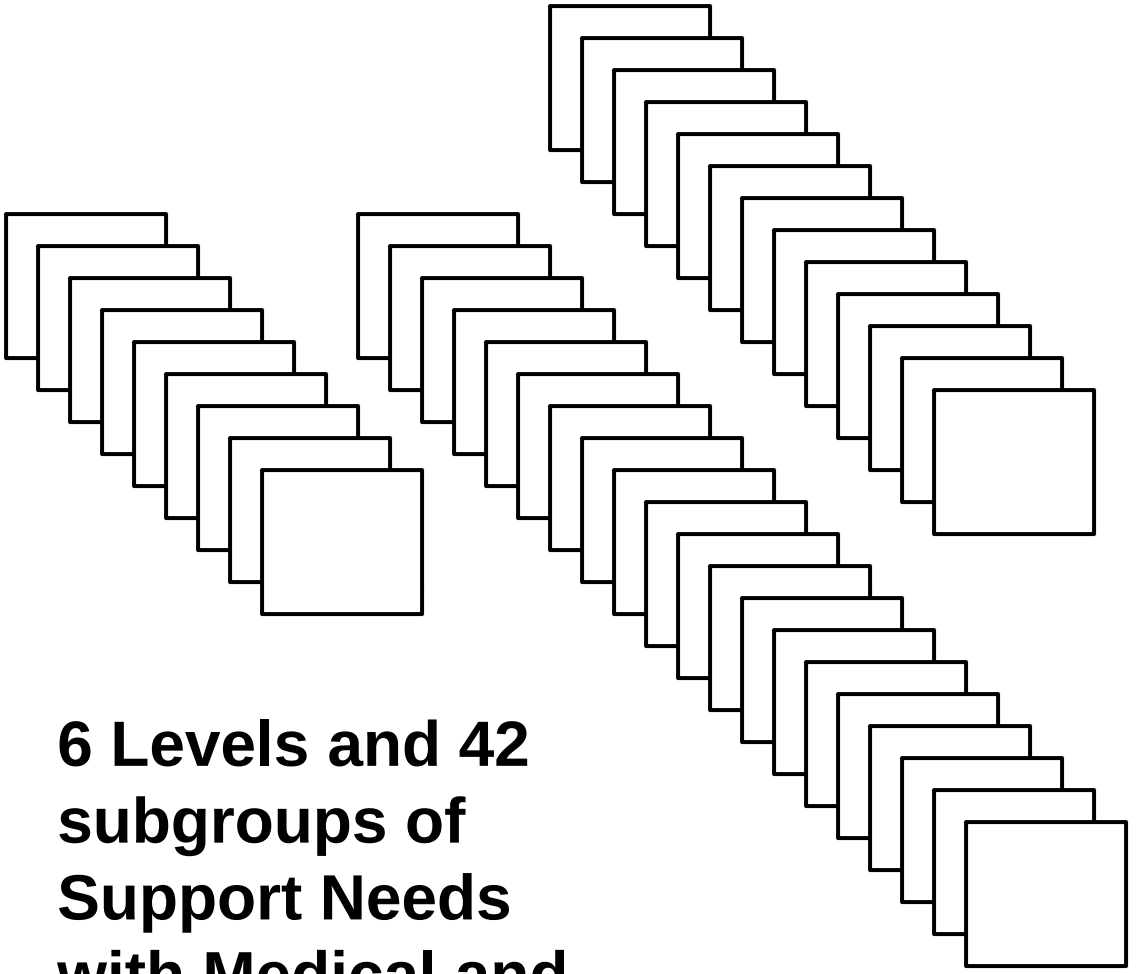
Colorado and Oregon

Colorado Level Model

Fits Individual SIS results from Oregon

In Colorado

Support Needs In Six Levels structured by 4 main groups of Section 1 ABE Results



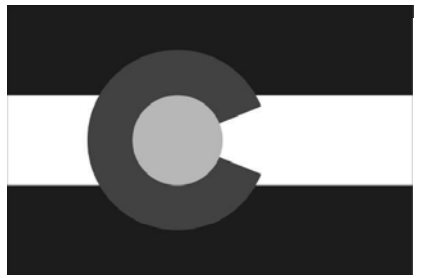
6 Levels and 42 subgroups of Support Needs with Medical and Behavioral

Community Safety Risk Two Levels

For CO 6 Levels of Funding Were Used

- 6 levels of funding were identified to better match individual support needs with funding based on:
  - 4 groups of SIS general adaptive scores
  - 42 subgroups of SIS Medical, SIS Behavioral and SIS adaptive scores (ABE) and a community safety risk factor
- In the community, as the levels increase from 1 to 6 the overall support needs of the individuals increase as do dollars

We Used the Solution in CO to support OR



CO's 6 Levels Offered a Better Fit Solution

- We thought that a SIS configuration used in Colorado may offer a better fit solution.
- Work involving the CO Comprehensive Waiver was completed using "full population SIS results" (n=3,631)
- The SIS configuration applied there uses six levels composed of 42 detailed subgroups.
- We tested for differences between the OR sample and CO full population. We found that the two are comparable.
- Applying it to the Oregon sample provides opportunity for "fine tuning" assignments to levels

6 Six Assessment Levels

Levels Adult Residential	People in Sample	Type of Need
1	70	Milder Support Needs
2	49	Moderate Support Needs
3	51	Severe Support Needs (SN)
4	30	Severe SN with Moderate Behavior & Medical
5	63	Severe SN with More Serious Behavior & Moderate Medical with Community Safety 30%
6	56	Severe SN Extraordinary Medical and Behavioral with Community Safety 50%

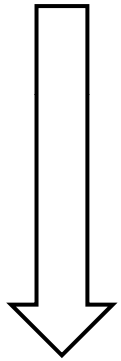
6 Levels for "DD50" Adult Residential Services

Levels	ABE	Medical Problems	Behavioral Problems	Risk	DD50 Staff Direct Hours
1	24	1	2	0	6
2	29	2	4	0	7
3	32	3	5	0	7
4	34	4	6	0	10
5	34	5	6	30%	12
6	35	7	9	50%	12

6 Levels Offers a Better Fit Solution because of…

- Adding another level improves managing of the "spread" in the sample pertaining to the relationship between assessed needs and dollars or service hours
- Separation between levels in dollars and service hours is improved
- Exceptional care and cost cases are better accounted for
- Overall, it allows for improved assignment to levels for individuals, and improved ability to assign budget allocations

The Colorado Comprehensive waiver six support levels



condense to four support (SLS) waiver caps or levels

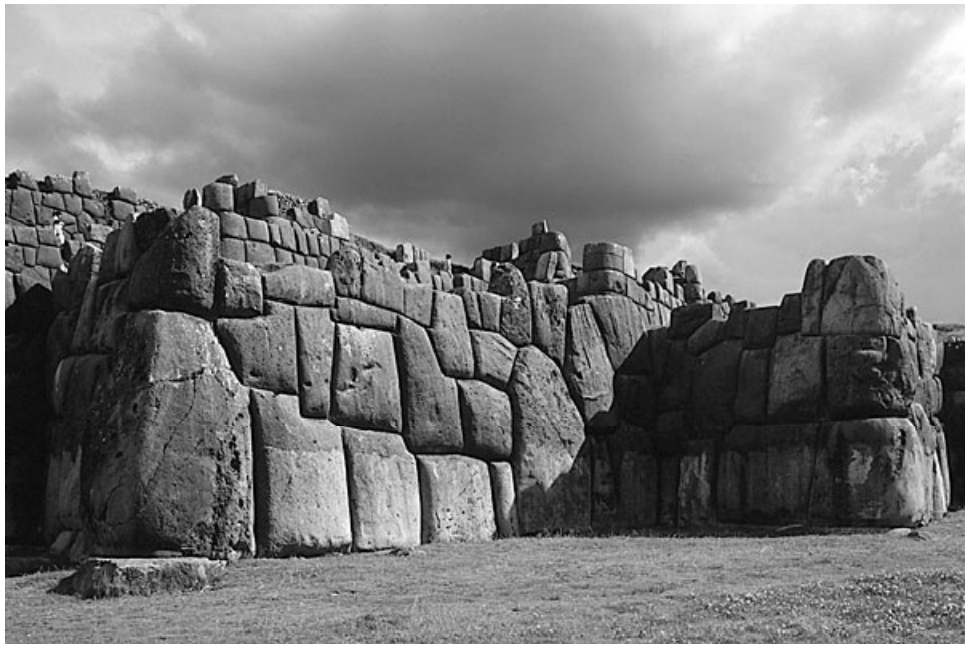
Support Levels	People	Average	Median
1	1,111	10,818	$10,200
2	705	14,866	$14,279
3	210	18,040	$17,434
4	150	18,172	$17,723
5	176	18,820	$18,685
6	177	18,751	$19,340
Total	2,529	14,094	$13,131

SLS Spending Cap*	Support Levels	Number of People	Average Paid Claims for FY08	Median of Paid Claims for FY08
A	1	1,111	$10,818	$10,200
B	2	705	$14,867	$14,279
C	3 & 4	360	$18,106	$17,582
D	5 & 6	353	$18,786	$19,059
Total		2,529	$14,095	$13,131

*Fortune, et.al. Colorado Supported Living (SLS) Waiver. (February 2009). HSRI. Portland, OR. Colorado will reexamine these levels and dollars in the spring of 2009 due to budget and economy restraints.

Virginia and Louisiana

Virginia System Model Level Prototype

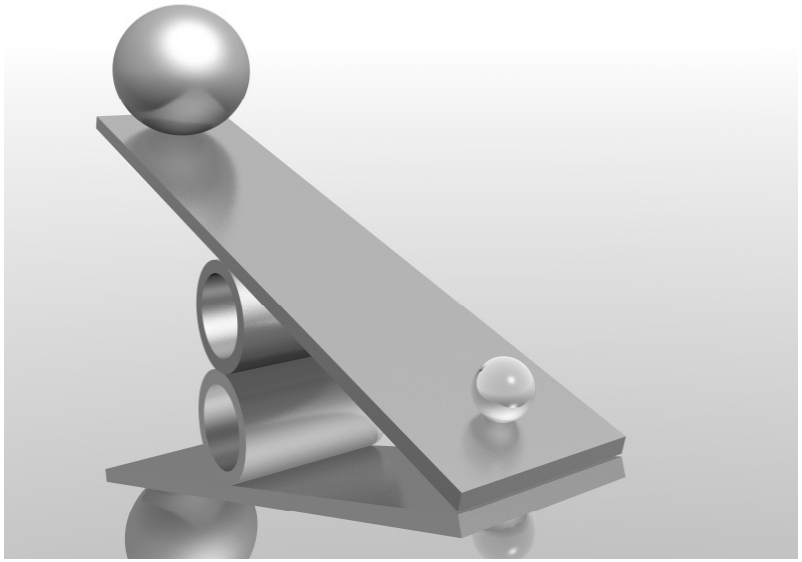


Fits Individual SIS results from Louisiana

6 Levels of Funding First Used in Virginia

6 levels of funding were identified to better match individual support needs with funding based on:

- 6 levels of SIS Medical, SIS Behavioral and SIS adaptive scores (ABE)
- In the community, as the levels increase from 1 to 6 the overall support needs of the individuals increase as do dollars



The 6 Levels

Level 1: Individuals with below-average support needs

Level 2: Individuals with average support needs

Level 3: Individuals with above-average support needs

Level 4: Individuals with low-average to slightly above average support needs but high behavioral needs

Level 5: Individuals with extraordinary medical support needs

Level 6: Individuals with extraordinary behavioral support needs

VA Going Forward

- Complete SIS administration for all individuals on the waivers by 2012
- Assuring consistency of SIS administration
- Constructing a community safety risk factor for supplemental questions
- Supplementing questions in the SIS by adding natural support measures
- Handling individuals with extraordinary needs
- Use existing night time supervision hours

Focus on Louisiana

Objectives

- Using standardized assessment, develop guidelines for authorization of NOW waiver IFS and ACS services
- IFS – Individual and Family Support – kind of a catch all to include attendant care and habilitation
- ACS – Attendant Care Services – which is really a payment to the provider agency to manage the clients IFS services.
- Develop a model to allow implementation of guidelines in a standardized way

The 7 LA Levels similar to VA

Level 1: Individuals with low-average support needs

Level 2: Individuals with below-average support needs

Level 3: Individuals with average support needs

Level 4: Individuals with above-average support needs

Level 5: Individuals with low-average to slightly above average support needs but high behavioral needs

Level 6: Individuals with extraordinary medical support needs

Level 7: Individuals with extraordinary behavioral support needs

LA Objectives - Draft Model

2 models:

- Living with family
- Independent living

Living Arrangement X	
SIS Level	Base Rate (Units/$)
Age	± Units/$
Natural Supports	± Units/$
Day Activities	- Units/$
Recommended IFS/ACS	**Units/$**

LA Objectives - Draft Model

Produces a guideline amount and reference point to set the basis for planning

- Not all of the recommended amount has to be used
- If more units/$ are required, additional authorization can be sought for individuals with special circumstances

LA Objectives - Process

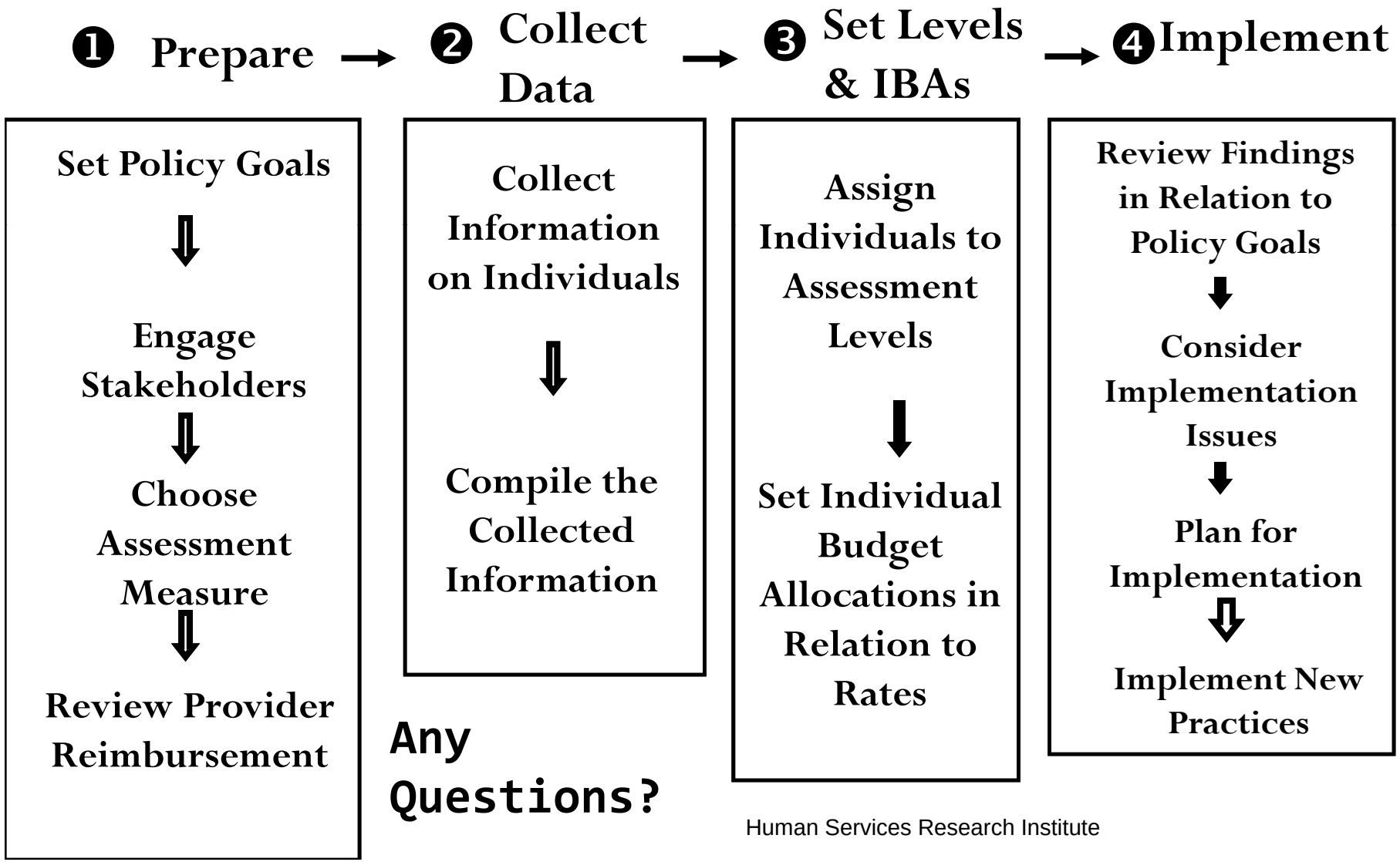
- Administer SIS assessment to sample population
- Review portion of SIS sample
- Model Development for People Waiting for Waiver
- Model Implementation for People Waiting for Waiver
- Future Model Development, Review, and Implementation with full NOW waiver population SIS results and studies of clinical review and financial impact

LA Case Reviews

- 127 cases being reviewed
- Resource allocation is used informally to inform support coordinators when to more closely examine documentation of need
- Items reviewed
  - Overall Case
  - Amount of Natural Supports
  - Existing and possible revised authorizations for
    - IFS – Individual and Family Support – includes attendant care and habilitation
    - ACS – Attendant Care Services – payment to the provider agency to manage the clients IFS services
    - Day Programs

Overview of the Strategic Planning Process

Developing Individual Budgets In Relation to Service Payment Rates



Any Questions?

About HSRI and the Authors

The Human Services Research Institute (HSRI) was founded in 1976 and is a non-profit, tax-exempt corporation with offices in Cambridge, Massachusetts and Portland, Oregon. For over 30 years, HSRI has assisted states and the federal government to enhance services and supports to improve the lives of vulnerable citizens, such as those with developmental disabilities or mental illness, or low income families. HSRI has provided consultation in such areas as strategic planning and organizational change, funding, systems integration, quality management and assurance, program evaluation, evidence-based practices, family support, self-advocacy, self-determination, and workforce development. For more information, visit: www.hsri.org.
This presentation was prepared by the following staff:

John Agosta, Ph.D., is an HSRI Vice President. He completed his doctorate in Rehabilitation Research at the University of Oregon, specializing in research methods and community supports for people with disabilities. Employed at HSRI since 1983, he has been involved with nearly all efforts at HSRI surrounding family support issues, facilitated development of strategic plans, conducted analyses of state systems for people with developmental disabilities (e.g., Arkansas, Florida, Illinois, Idaho, Oregon, Hawaii, and Texas), and has studied specific facets of the field (e.g., trends in supported employment, managed care, self-determination). He is a nationally recognized expert in topic areas such as family support, self-directed supports and community systems regarding policies that affect individuals with developmental disabilities. He leads the project at HSRI called Sage Resources Person Centered Funding, visit www.sageresources.org. This effort concentrates on assessment informed person centered adult waiver reimbursement techniques.

Karen J. Auerbach, Ph.D., is currently working as a Statistician and Senior Research Analyst on several developmental disabilities projects at HSRI, primarily on the National Core Indicators project and the Sage Resources Person Centered Funding project. Over the past twelve years she has developed her research, analytic, and data management skills on education and substance use research projects at the Harvard Graduate School of Education, Boston College, the Education Development Center in Newton, MA, and at Pennsylvania State University. She has a Masters in Developmental and Educational Psychology from Boston College, and a Masters and Ph.D. in Human Development and Family Studies with a minor in Statistics from Penn State. She has worked on reimbursement in British Columbia, Colorado, Oregon, Rhode Island, and Virginia.

Jon Fortune, Ed. D., is a Senior Policy Specialist at HSRI. He received his doctorate from the University of Northern Colorado. Dr. Fortune has solid research skills as well as hands on experience as a state administrator. In 1990, he joined the Wyoming Department of Health Developmental Disabilities Division where he has held senior management positions. He was instrumental in designing and implementing Wyoming's system of community services for people with developmental disabilities and acquired brain injury, including developing Medicaid HCBS waivers for both populations. During his tenure in Wyoming, the state substantially reduced the number of people served in its large state facility and built an especially strong system of quality community supports. Dr. Fortune was also the chief architect of the precedent-setting Wyoming DOORS model through which people with disabilities are assigned individual budgets based on their assessed needs and other factors. Prior to joining the Wyoming Department of Health, Dr. Fortune managed a community agency in Wyoming and held other positions in Colorado and Illinois and is currently working on financial architecture in DD statewide services systems in ten states.

Madeleine Kimmich, D.S.W., a Senior Research Fellow in HSRI's Oregon office, currently co-directs the office and leads several projects in child welfare and in developmental disabilities. She received her doctorate in social welfare policy from the University of California-Berkeley. Dr. Kimmich has been engaged in evaluation research and policy analysis of human services for over three decades. She has assisted decision-makers at federal, state, and local levels to work collaboratively with consumers and families to improve the effectiveness of programs targeted to low-income children and families, adolescents, the elderly, and people with disabilities. Dr. Kimmich currently leads an analysis of Oregon's public sector efforts to address substance abuse. She also directs a 12-year evaluation of Ohio's Title IV-E Waiver Demonstration Project, which examines the impact of flexible but limited federal funds on local child welfare reform initiatives. She currently participates on HSRI's team to develop HCBS waiver reimbursement methodologies, and has contributed to the development of performance indicators for consumer-directed service approaches in developmental disabilities. As co-editor of *Quality enhancement in developmental disabilities: Challenges and opportunities in a changing world (2002)* and as director of numerous state-level studies on quality management, Dr. Kimmich has maintained an active presence in the quality assurance and systems improvement arena, to increase efficiency and equity of service and support systems for all vulnerable populations.

Drew Smith, B.A., is a Policy Assistant at HSRI. He is a graduate of Portland State University in Business Administration, and currently works on several HSRI projects tied to: developing person-centered funding strategies, assessing the impacts of service changes and reductions, and supporting self-advocacy. He has worked on waiver reimbursement projects in Colorado, Florida, Oregon, Rhode Island, and Virginia.

Kerri Melda, M.S., is a Policy Associate at HSRI. She holds a Master's Degree in Public Policy and Administration (University of Oregon) and a Bachelor's Degree in Special Education (Indiana University). Ms. Melda has been employed with HSRI since 1992, and her primary responsibilities include project leadership, policy and statistical analyses, program evaluation, and provision of training and technical assistance. Specifically, her work focuses on projects related to family support policy and practice, person-centered funding, performance gap analyses, and studies assessing the impact of change on service recipients. Ms. Melda currently serves as Director of HSRI's Juntos Podemos (Together We Can) Family Center, connecting Latino families who have children with disabilities to community services and supports. She oversees the family support related activities of the National Core Indicators project, which analyzes family support satisfaction data across 30 states. She recently completed a study of the impact of service reductions on Florida's service population, and has worked on reimbursement projects in Colorado, Rhode Island, and Virginia.

Sarah Taub, M.M.H.S., is a Policy Associate at HSRI. She carries primary responsibility for managing the National Core Indicators (NCI), a collaborative effort of HSRI and NASDDDS that began in 1997 to develop indicators and benchmarks of performance across state developmental disabilities service systems. She also provides technical assistance under the CMS National Contractor on Quality in HCBS Services and works on various projects related to program evaluation. She holds a Masters Degree from the Heller School at Brandeis University. She has worked on individual budgets in Colorado, Georgia, and Rhode Island.