Ten Issues for States to Consider in Implementing Individual or Level-Based Budget Allocations

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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.

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Introduction

Today's public service systems for individuals with developmental disabilities are buffeted by strong forces, challenging policy makers to restructure their service delivery systems. Increasing service demand, budget shortfalls, workforce shortages, reliance on legacy and often inefficient services, and mounting preferences for services that promote community integration and self-direction are among the factors pressing on developmental disability systems. Working within this context, policy makers are seeking to re-design systems to achieve greater *efficiency* and *equity*. By doing so, they hope to make better use of available funding while better positioning their systems going forward.

Factors Influencing Service Restructuring:

- Increasing service demands
- Budget shortfalls
- Workforce shortages
- Reliance on legacy/ inefficient services
- Preferences for community integration and self-direction

Policy Makers Re-Design Systems to Achieve Greater:

- Efficiency – spending precisely what is needed, no more and no less.
- Equity – a fair allocation of resources across all served, tied to assessed support needs.

- *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. Ideally, the individual is allocated precisely what is needed, no more and no less. Most developmental disability jurisdictions, however, know little about actual costs per person. Policy makers may know what is being spent per year per person, but not what it actually costs to serve that person.

- *Equity* requires understanding what supports individuals need, and making a fair allocation of resources across all those served. Few systems, however, utilize protocols to reliably assess individual support needs and translate such findings into efficient and equitable resource allocations. Over time and across geographic areas, decisions made about service awards often appear idiosyncratic and unfair. Policy makers are seeking ways to allocate resources more systematically and with greater empirical confidence. It is important to assure that individuals are assigned budget allocations to match their needs, no more and no less. Equity[1] means being fair but it does not mean everyone gets the same budget allocation. Equity also means that uniform rates are developed for all waiver services (with the option for making those rates variable by support needs of individuals), such that all providers would receive the same rate for the same service for individuals with similar needs.

Human Services Research Institute (HSRI) is currently working with several states to design more rational and defensible reimbursement levels and/or individualized budgets

[1] Equity = the state of being just, impartial, and fair. (American Heritage College Dictionary)

for service recipients This work is relevant to any state, regardless of its present application of self-direction principles. The key starting point is a standardized assessment of individual support needs. HSRI uses the individual assessment information in conjunction with past funding expenditures to uncover the decision rules a state has employed for resource allocation. Working from this point, states can move toward a protocol for allocating resources that is more equitable and more responsive to state programmatic parameters, accountability, efficiency, and legitimacy of costs.

What follows in this paper are summaries of:

a) Eight states that have recently undertaken efforts to develop individual or level-based budget allocations for people with developmental disabilities who participate in Home and Community-Based Services (HCBS) waivers;

b) The strategic framework HSRI has developed to achieve needed system improvements; and

c) Ten common issues or concerns that states have encountered throughout the process to develop individual or level-based budget allocation models, and examples of how states have addressed each issue.

Selected State Efforts to Develop Individual or Level-Based Budget Allocations

As stated above, HSRI is currently working with several states to design reimbursement levels and/or individualized budgets for service recipients. In this paper, we highlight the efforts and cite examples of process and implementation strategies from eight states in particular: Colorado, Florida, Georgia, Louisiana, Missouri, Oregon, Rhode Island, and Virginia. To provide some context and a better understanding of the circumstances within each state that led to a system redesign, we offer the following information for each state:

a) HCBS Population and Spending Data: The most recent (2007) data[2] from the University of Minnesota Research and Training Center on Community Living indicates the number of people served, the amount of money spent per person, and overall spending for each state's Home and Community Based Services waiver(s). Additionally, an overview of the growth trend, between 2000 and 2007, for each of these areas is described. The table below provides a comparison of population and spending growth across the eight states, along with national averages.

b) State Efforts Tied to IBA or LBA Development: Information about the state context or impetus for change is offered, along with an overview of the goals

[2] Prouty, R.W., Alba, K., & Lakin, K.C. (2008) Residential services for persons with developmental disabilities: Statuses and trends through 2007. Minneapolis: University of Minnesota, Research and Training Center on Community Living.

related to Individual Budget Allocation (IBA) or Level-Based Budget Allocation (LBA) development. We also note the level of HSRI's involvement, ranging from selective consultation to resource allocation model design, to in-depth system analysis and redesign.

c) Current Status: A description of the current status of development and/or implementation of IBAs or LBAs. This section also includes, where available, an update of population and spending data, garnered through HSRI's continuing involvement.

Eight States and their HCBS Service and Expenditure Trends (2000-2007)

State	Number of HCBS Recipients			Average Spending per HCBS Recipient			Total HCBS Spending (in $ millions)		
	2000	2007	Avg. Annual Growth - %	2000	2007	Avg. Annual Growth - %	2000	2007	Avg. Annual Growth - %
CO	6,330	7,148	1.8%	$30,214	$37,504	3.3%	$191	$268	7.5%
FL	21,126	31,425	6.2%	$11,921	$28,912	14.3%	$252	$909	22.9%
GA	2,468	9,194	25.5%	$37,301	$28,665	-3.0%	$92	$264	18.5%
LA	3,629	6,915	9.9%	$26,281	$37,342	5.9%	$95	$258	20.0%
MO	8,238	8,396	0.3%	$24,142	$45,192	9.6%	$199	$379	9.6%
OR	5,824	10,287	8.9%	$39,879	$37,500	-0.6%	$232	$386	5.2%
RI	2,471	3,126	3.4%	$58,935	$78,542	4.4%	$146	$246	11.4%
VA	4,635	7,523	7.3%	$31,186	$52,416	7.9%	$145	$394	17.8%
United States	291,255	501,489	8.1%	$33,113	$40,467	3.0%	$9,644	$20,294	12.3%

Source: Prouty, R.W., Alba, K., & Lakin, K.C. (2008) *Residential services for persons with developmental disabilities: Statuses and trends through 2007*. Minneapolis: University of Minnesota, Research and Training Center on Community Living

1. Colorado

HCBS Population and Spending Data: In 2007, Colorado supported 7,148 individuals through its HCBS waivers, at an average cost of $37,504 per individual served, and a total cost of $268,080,321. Colorado experienced steady HCBS waiver growth between 2000 and 2007. During this time, the number of people receiving HCBS grew at an average annual rate of 1.8%; average costs per person grew at an average annual rate of 3.3%; and overall HCBS spending increased, on average, 7.5% per year.

State Efforts Tied to IBA or LBA Development: Under pressure from the Centers for Medicare & Medicaid Services (CMS) to create more equity in waiver spending tied to participant support needs in order to comport with Federal statute and regulations, particularly across sub-state jurisdictions, Colorado chose to begin using the Supports Intensity Scale (SIS). The state undertook extensive analysis of the current paid claims, SIS data, and data from state-added supplemental questions to the SIS. HSRI supported Colorado's efforts to design new SIS-informed Support Level or Cap Systems for participants in the State's Comprehensive waiver or Supported Living Services (SLS) waiver. The state now has a six-level Funding Allocation System for the Comprehensive waiver and four spending caps (using the framework of the six support levels from the Comprehensive waiver) for the SLS waiver.

Current Status: Colorado currently supports 6,698 individuals with developmental disabilities on its two HCBS waivers at an average cost per person of $41,093. The model for the Comprehensive waiver was completed in 2007 and rolled out on January 1st 2009 across Colorado. The model for the SLS waiver was developed and approved by CMS in the renewal application in February 2009, with an anticipated statewide rollout in July 2009.

2. Florida

HCBS Population and Spending Data: In 2007, Florida served 31,425 individuals through its HCBS waivers, at an average cost of $28,912 per individual served, and a total cost of $908,572,039. Florida experienced considerable HCBS waiver growth between 2000 and 2007. During this time, the number of HCBS participants grew, on average, at a rate of 6.2% per year, while the average costs per person increased, on average, a more dramatic 14.3% per year. The combined growth in numbers served and amount spent per person has led to an overall average annual growth in HCBS spending of 22.9%, nearly double the national average growth rate of 12%.

State Efforts Tied to IBA or LBA Development: In recent years, Florida's Agency for Persons with Disabilities (APD) overspent its approved budgets, and has since faced legislative criticisms about its management of the state's developmental disability services. The legislature mandated the implementation of four new tiered waivers with spending caps to replace the state's previous system. In 2008, APD contracted with the University of Southern Florida (USF) to complete psychometric work regarding the use of the state-developed Questionnaire for Situational Information (QSI) to assess service recipient needs for assistance. In turn, USF sub-contracted with HSRI to complete selected tasks and provide direct consultation to APD on the validity of the QSI assessment tool, key leadership issues, early decision points, policy issues to consider, and consultation on the formation of individual budgets.

Current Status: In March 2009, Florida announced that it had administered the QSI to 85% of the waiver participants, and that it anticipates completing assessment of all waiver participants and the 18,000 people on the waiting list by the end of summer 2009. Florida implemented movement of all waiver participants to a CMS-approved four-tiered waiver system in October 2008, and reports that the $1.1 billion budget for developmental disability services to be overspent by only one percent (1%) this year. APD has also announced plans to develop a new resource allocation system over the next few years based on individual-level QSI and expenditure data.

3. Georgia

HCBS Population and Spending Data: In 2007, Georgia supported 9,194 individuals through its HCBS waivers, at an average cost of $28,665 per individual served, and a total cost of $263,542,265. Georgia experienced rapid HCBS waiver growth between 2000 and 2007. During this time, the number of HCBS recipients grew, on average, at a rate of 25.5% per year, while the average costs per person decreased,

on average, 3.0% per year. This decrease was largely influenced by a significant decrease in per person spending that took place in 2003. With this growth in people served, and decrease in average spending per person, overall HCBS spending increased, on average, 18.5% per year.

State Efforts Tied to IBA or LBA Development: Georgia is known for having the oldest comprehensive HCBS waiver, is the originating locale of the Olmstead U.S. Supreme Court decision, and is the state often ranked last in the nation for fiscal effort regarding developmental disability services. Given this history, Georgia sought to reinvigorate its developmental disability system, and, with the hiring of new leadership, the Office of Developmental Disabilities undertook collaboration with HSRI to develop an algorithm for forming Individualized Budget Allocations for the state's entire population of people with developmental disabilities. These individuals are funded through either the state's Comprehensive or Georgia New Opportunities Waiver (NOW) Support waivers.

Current Status: Georgia currently supports 10,500 individuals with developmental disabilities on its two HCBS waivers at an average planned cost, per person, of $33,314. To date, the state has rolled out 10,500 IBAs produced with a SIS-informed individual budget model along with new comprehensive and support waivers which began at the end of November 2008. HSRI continues to provide consultation to the state by examining the routine development of new individual budgets and the careful documentation on the individuals who present exceptional care and cost needs. Georgia has also launched an effort to enhance the program quality of its services and develop an effective statewide risk management plan.

4. Louisiana

HCBS Population and Spending Data: In 2007, Louisiana supported 6,915 individuals through its HCBS waivers, at an average cost of $37,342 per individual served, and a total cost of $258,219,940. Louisiana experienced considerable HCBS waiver growth between 2000 and 2007. During this time, the number of HCBS participants grew, on average, at a rate of 9.9% per year, while the average costs per person increased, on average, at a slightly slower pace of 5.9% per year. Combining the growth in people served and in average spending per person, overall HCBS spending grew at an average annual rate of 20.0%.

State Efforts Tied to IBA or LBA Development: The impetus for Louisiana's initiative was to satisfy state political leaders that the large number of people who would leave the state's waiting list and move to the NOW waiver would not double in cost over the next few years, as had happened with the existing NOW waiver group. The goal was to design a Louisiana resource allocation model for adult participants, using a standardized SIS assessment, for authorizing NOW waiver Individual Family Support and Attendant Care Services hours. Throughout 2007 and 2008, HSRI worked with Louisianans to help them better understand their options for improving the State's HCBS Waiver programs. In particular, the Office for Citizens with Developmental Disabilities (OCDD) contracted with HSRI and Burns & Associates,

Inc. to develop a six-level reimbursement resource allocation system for its HCBS NOW waiver.

Current Status: Louisiana currently supports 6,986 individuals with developmental disabilities on its HCBS NOW waiver, at an average cost per person of $59,951 which was a dramatic jump from $37,000 in 2007. The state is beginning to provide services to 2,013 individuals from their waiting list in the NOW waiver program. The resource allocation level model is currently used as an informal guide or reference point during the support planning process. In special needs situations, individuals (supported by their families and friends, as appropriate) can request more hours than predicted by these internal guidelines. The state continues to give the SIS statewide.

5. Missouri

HCBS Population and Spending Data: In 2007, Missouri served 8,396 individuals through its HCBS waivers, at an average cost of $45,192 per individual served, and a total cost of $379,435,294. Between 2000 and 2007, Missouri experienced very little growth in its HCBS waiver population yet consistent growth in HCBS spending. During this time, the number of HCBS recipients grew, on average, at a rate of 0.3% per year, while the average costs per person increased, on average, 9.6% per year. Combining the growth in people served and average spending per person, overall HCBS spending increased, on average, 9.6% per year over the seven-year period.

State Efforts Tied to IBA or LBA Development: Missouri serves most individuals through a comprehensive waiver. There is also a small support waiver and a small waiver for children with developmental disabilities who are medically fragile. Low utilization of services by some, challenges in eligibility, and an extended history of people waiting to move off waiting lists into the appropriate waiver created some of the pressures in realigning the state's budget with people's support needs. The work is challenging because of county tax-based waiver revenue differences, a long history of negotiated contracts, and some blended per diem group home payments. The state is committed to statewide SIS interviews and has shared with HSRI the results for 2,730 waiver participants.

Current Status: Missouri in FY09 supports 14,041 people at an average annual cost of $29,770 (representing a substantial increase in people served, and decrease in dollars spent per person, compared with 2007). The Division of Developmental Disabilities provided in-home supports to 8,294 individuals at a cost of nearly $50 million and residential supports to 5,747 individuals at a cost of nearly $368 million. The state is considering the formation of SIS-informed individual budgets for its three waivers by 2010, and examination of the legacy waiver rate system. The work relies heavily on use of HSRI's 20,500-person SIS dataset.

6. Oregon

HCBS Population and Spending Data: In 2007, Oregon served 10,287 individuals through its HCBS Waivers, at an average cost of $37,500 per individual served, and

a total cost of $385,761,698. Between 2000 and 2007, Oregon experienced steady HCBS waiver growth. During this time, the number of HCBS recipients grew, on average, at a rate of 8.9% per year, while the average costs per person decreased slightly, on average, 0.6% per year (like Georgia, this overall decrease is largely influenced by a significant decrease in per person spending that took place in 2003). Combining the growth in people served and the decrease in average spending per person, overall HCBS spending increased, on average, 5.2% per year over the seven-year period.

State Efforts Tied to IBA or LBA Development: Oregon's Department of Human Services/Seniors and People with Disabilities (DHS/SPD) has been working to develop a new system for funding the Comprehensive HCBS waiver services for people with developmental disabilities, through its Rebalancing Budgets and Rates (ReBAR) project. The project's goal is to replace the current legacy system with a new system that will establish individual level-based budgets for approximately 3,600 service recipients, standardize rates for services delivered, and support a statewide network of community providers. HSRI and other consultants have worked to develop a leveling system for assigning individuals by support needs.

Current Status: In March 2009, the state finished administering the SIS and implementing new budget amounts for 300 people receiving the lowest waiver reimbursement for residential services. To ensure their well-being, over half of the individuals were moved to higher funding levels, including nine individuals who were found to have extensive community safety risk supervision needs. A second cohort includes the remaining 44 individuals residing at the state's last operating state-run institution in Pendleton. The individuals will be relocated into the community by the end of 2009. Over the next four years, the state plans to transform the entire comprehensive waiver with SIS-informed resource allocation.

7. Rhode Island

HCBS Population and Spending Data: In 2007, Rhode Island served 3,126 individuals through its HCBS waivers, at an average cost of $78,542 per individual served, and a total cost of $245,521,023. Between 2000 and 2007, Rhode Island experienced steady HCBS waiver growth. During this time, the number of HCBS recipients grew, on average, at a rate of 3.4% per year, as did the average annual per person spending (up, on average, 4.4% per year). Combining the growth in people served and average spending per person, HCBS spending increased, on average, 11.4% per year over the seven-year period.

State Efforts Tied to IBA or LBA Development: Rhode Island is considered by many to be one of the better state systems for developmental disability services. It eliminated residential institutional care in 1995 (moving all residents into small group homes), has only 41 people in ICFs/MR care, and has one of the best individual risk management quality enhancement systems. However, more recently, Rhode Island has faced one of the highest unemployment rates in the United States, and experienced severe decreases in the state budget. This has prompted a seven percent (7%) cut to developmental disability services from July 2008 to January

2009. In the midst of this, in collaboration with Burns & Associates, HSRI has been working with state leaders, stakeholders, family members, self advocates and others to use the SIS and supplemental measures to build Individual Budget Allocations (IBAs) for a pilot 500-person random sample of individuals receiving services from the state's Developmental Disabilities Division (DDD). During this ongoing project HSRI plans to: (a) study SIS results for the 500 sampled individuals; (b) explore ways to design rates for RI's DD reimbursement system and compare their expenditure data with a select comparison group of states; and (c) provide a work plan and make recommendations for building assessment-informed person-centered funding for Rhode Island's entire population of individuals receiving services and supports from DDD.

Current Status: Rhode Island currently supports 3,600 individuals with developmental disabilities on its HCBS waivers at an average cost per person of $68,611. This reflects direct reductions to the DDD service system of 7% from July 2008 to January 2009. Due to challenges related to expenditure data within the state, the scope of work for this project has changed from developing IBAs for a pilot group of 500 waiver participants. It is now geared toward understanding and reorganizing the expenditure information, as well as creating a detailed work plan for moving forward within the state. The initial SIS results for 56 individuals in an early random sample tentatively show support needs as measured by the SIS that appear to be similar to those in other states.

8. Virginia

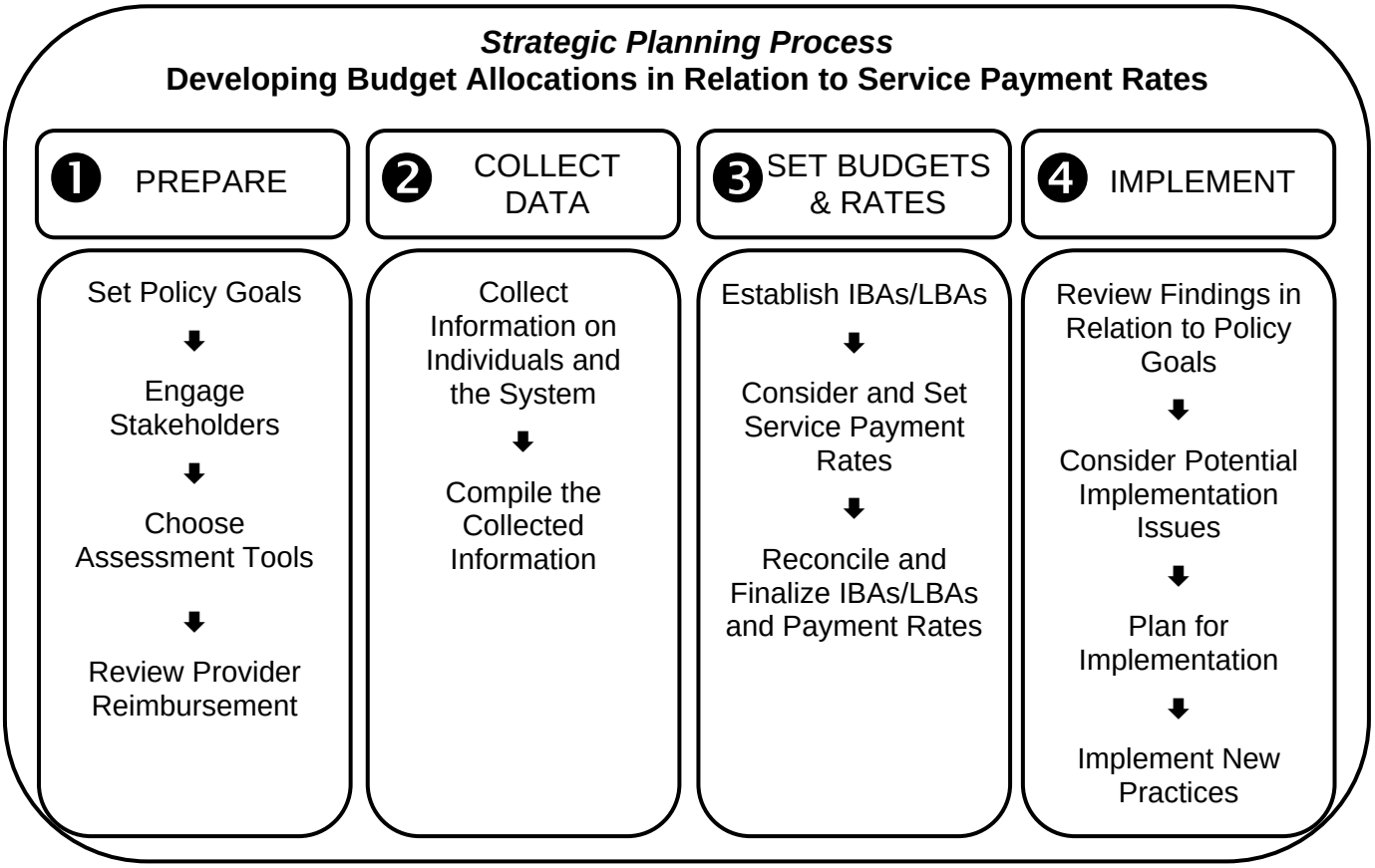
HCBS Population and Spending Data: In 2007, Virginia served 7,523 individuals through its HCBS Waivers, at an average cost of $52,416 per individual served, and a total cost of $394,326,044. Between 2000 and 2007, Virginia experienced steady HCBS waiver growth. During this time, the number of HCBS recipients grew, on average, at a rate of 7.3% per year, as did the average annual per person spending (up, on average, 7.9% per year).Combining the growth in people served and average spending per person, overall HCBS spending increased, on average, 17.8% per year over the seven-year period.

State Efforts Tied to IBA or LBA Development: Virginia wanted to design a resource allocation system, using the SIS, where resources would be deployed in a standardized fashion, and individuals with similar support needs and circumstances would receive comparable funding. This allocation system would then serve as an important stepping stone to the development and use of individual self-directed budgets. Using SIS results, HSRI developed for Virginia's Office of Mental Retardation Services (OMRS) a prototype five-level reimbursement model for 516 Comprehensive Waiver participants, and provided them with a report that fully documents the initial prototype development work. HSRI recommended the state collect full population assessment and expenditure data, and has supported them with on-going analytic updates. In addition, HSRI has provided OMRS with a roadmap that will enable OMRS to take over, maintain, and refine the system going forward.

Current Status: Following development of the initial model, OMRS intends to take over the development of future Virginia System models. The Virginia System will be applied by OMRS for approximately 7,209 individuals with mental retardation. Going forward, HSRI will develop individualized budgets and reimbursement levels for the state's three waivers, which may be consolidated and reorganized into a comprehensive waiver and a supports waiver. The state is currently collecting SIS interviews and other supplemental data on the full population of waiver recipients, with plans for completion by 2012.

Four Phases: A Strategic Planning Process to Develop Resource Allocation Models

HSRI has developed and refined a strategic planning framework which has proven useful in leading to needed systemic improvements. This approach has four main phases: (1) preparation for the project, (2) data collection, (3) setting individual assessment levels, IBAs/LBAs and service rates, and (4) implementation.[3]



[3] Kimmich, M., Agosta, J., Fortune, J., Smith, D., Melda, K., Auerbach, K. & Taub, S. (2009) *Developing individual budgets and reimbursement levels using the supports intensity scale*. Houston: Independent Living Research Utilization (ILRU) Community Living Partnership.

Phase 1: Preparatory Tasks

There are four preparatory tasks for resource allocation that coincide with the state's efforts to enhance the quality of its waiver services:

1. Policy makers must articulate their goals. While the overarching intent may be to improve the efficiency and effectiveness of resource allocation, under that umbrella may fall other policy goals:

    - Assuring that resources are authorized to individuals in ways that accurately and reliably account for personal support needs.
    - Assuring that resources are managed effectively and efficiently.
    - Assuring that services are reimbursed in ways that service providers are compensated with fair/adequate and reasonable rates.
    - Introducing participant direction into the delivery of services.
    - Assuring provider reimbursement rates reflect underlying system values and preferred outcomes.
    - Complying with the governmental requirements set by administering agencies and, for Medicaid-reimbursable services, Federal statute and regulations.

    At the project's outset, policy makers need to consider these and/or other policy goals, and indicate those that significantly influence the effort. These decisions will come into play later when addressing various issues that arise and judging the outcome of the effort.

2. Engage stakeholders throughout the course of the project. Stakeholders include service recipients, family members, service providers and others concerned with the outcome. Through a "Stakeholders Committee", broad input and feedback can be continually acquired to help ensure that the envisioned changes and their implementation are consistent with service system values and principles. This involvement also will contribute to ensuring the feasibility and practicality of the changes made.

3. Choose assessment tools to collect needed information about individuals and system performance. Essential to the effort is choosing an assessment tool that will provide sufficient information to accurately and appropriately differentiate among service participants with respect to their supports needs. For instance, the Supports Intensity Scale (SIS) is an assessment tool that is used by several states. Other tools are available and states may find it preferable to use legacy tools that have been in use for years. However, it is essential that the tool selected be capable of reliably assessing support needs and be useful in measuring the relationship between these needs and dollars expended.

4. Review Provider Reimbursement. Information must be collected on the amount of money that is expended annually for each participant. In order to be most useful

this expenditure information should not be biased by legacy reimbursement rates that are caused by differing geography-based and administrative jurisdictions, rates set to deal with specific deinstitutional events, or significant differences between providers resulting from a negotiation process. Removing the reimbursement system bias from the expenditure data may be an extensive task, but is essential to deriving IBAs/LBAs that satisfy the equity objective.

Phase 2: Data Collection

Data collection entails two steps: collecting the data and compiling it.

1. The first decision for a state to make regarding data collection is whether to begin with a small portion of the population or to gather information on all waiver recipients. Eventually, if new assessment practices and IBAs/LBAs are be implemented for all HCBS participants, the state will need, at some point, to have information on the entire population. But a state may find it more feasible, financially as well as practically, to start data collection with a representative random sample. As long as the sample is drawn properly, it can serve as a legitimate proxy for the entire population. This approach allows state policy makers to field-test crucial components of the change process: to learn how best to manage the data collection process, to smooth out logistical difficulties, and to explore the potential impact of changes in the resource allocation model. Larger samples increase the certainty of the results, especially where there are modest relationships between assessments and expenditures. Alternatively, policy makers may choose to start by assessing the entire population. While this requires greater investment at the onset, it makes for more reliable analysis of potential risks and impacts. Regardless of how a state begins the data collection process, it is advisable to delay implementing IBAs/LBAs until the standardized assessment tool has been administered across the entire population.

   It is crucial that the data collection is managed carefully and thoroughly. Otherwise it could significantly set back the reform effort. Success requires that data collectors are well trained and a precise process is in place to guide their actions. The assessments must be administered properly so that the funding application is built on a solid platform of consistent data. If there are questions about how well assessments have been performed or how reliable they are, the entire funding application will be thrown into doubt. And, as data are collected, managers must continually check to assure that the data are being collected accurately and without bias.

2. The second critical issue related to data collection is proper compilation of the information. Accuracy and reliability must be assured. This requires reviewing data for completeness, internal consistency, and possible error patterns. Catching omissions or errors early can greatly reduce problems at the data analysis and interpretation stages.

Phase 3: Levels or Individual Budgets and Rates

Two considerations are associated with setting levels and payment rates:

1. Deciding to develop "Level-Based Budget Allocations" or "Individual Budget Allocations." Information on individual support needs can be used to do either of the following:

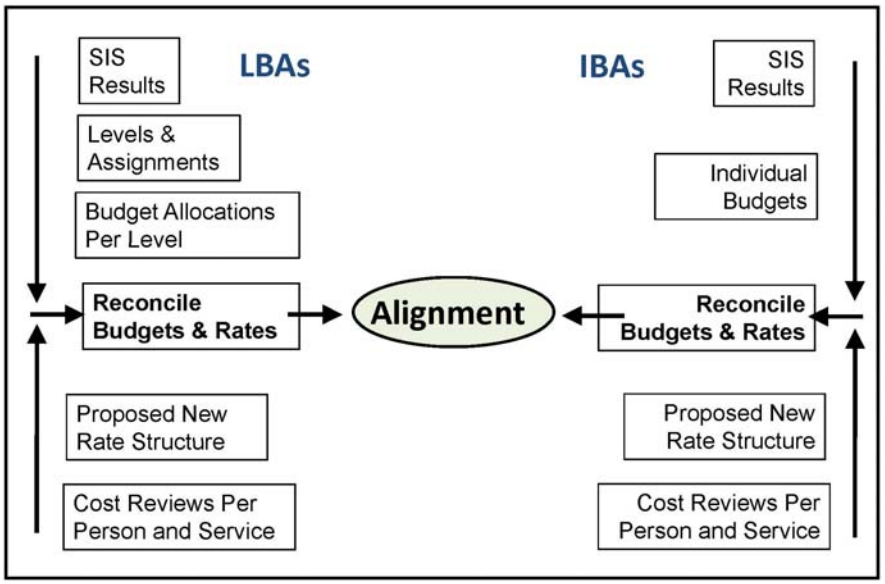
    - Set Level-Based Budget Allocations (LBAs). The support needs of individuals are systematically analyzed in relation to costs (and perhaps direct service hours). Items in the selected assessment tool are examined in a variety of ways to determine what combinations of variables can best explain variance associated with targeted dependent variables (e.g., annual costs and/or a measure of services hours). The analysis is used 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. Ideally, total waiver expenditures and hours of support change in relation to changes in assessment level. The number of levels and their composition are dictated by the data set. The levels can be tested against two major service categories: residential services and day services; or can be tested by living situation: group home, independent living, and living with family. It is worth noting that this process results in defined levels composed of individuals who are assigned to each level. All individuals falling within a level are assigned the same allocation (unless finer distinctions are made within levels, such as by creating sub-levels).
    - Set Individual Budget Allocations (IBAs). If the data allow, it is possible for individuals to claim their own unique level, resulting in "true" individualized budget allocations. Again, it is presumed that individuals with greater needs should have access to more resources; those with lesser needs should get less. Yet, it is understood that each individual has his or own unique needs; no two people have the same needs and priorities. It is presumed that individuals and their planning teams know best what services are most important for that person. IBAs are decidedly not based on a preset determination of need for a particular provider. Inevitably, people should choose providers, not the other way around. As a result, an IBA is both individualized to one's need, but personalized because of how the allocation is spent later.

      Achieving this level of precision, however, can be hard to do initially. IBAs are calculated by computer through systematic analysis (as described above), but each individual is granted his/her own "level" or allocation.

      The IBA is portable, as is an LBA. The individual waiver participant controls the funding and the choice of service provider. This compares with the service provider being reimbursed by the state to provide service to a client. The

person chooses the provider and the money moves with the person. There are no "guaranteed clients." IBAs or LBAs are also prioritized because the waiver participant and the interdisciplinary team set priorities and because people with the greatest need get the most. Finally the IBAs/LBAs are predictable because both the individual and the state system know and plan within their limits.

2. Setting and reconciling service payment rates based on historical costs and assignment to levels or IBAs. Regardless of whether IBAs or LBAs are applied, individual allocations must be based upon unbiased reimbursement rates. Depending on the results from an evaluation of the current reimbursement system, states may decide either to use the existing rate structure or take the opportunity to adjust reimbursement rates to eliminate biases in the legacy system, better define the costs (and services), increase the overall amount of reimbursement, or encourage certain service types over others. In general, our approach to rate determination stresses the application of a standard rate-determination framework that bases rates on the level of direct staff effort necessary to deliver a particular service and on observed usual and customary provider costs. This approach is designed to yield payment rates that are directly related to standardized service costs.



Central to this framework is the fundamental rate determination principle that a state's payments for services should ensure that each provider of a service receives sufficient compensation to support the delivery of necessary services to each individual. In such a situation, payments for community services will be based on assessed differences in support needs (based on a standardized assessment of such needs), while still promoting the economical and efficient delivery of services. In IBA/LBA, there is the potential need for a process that allows for an individual to set rates higher than what the state has decided the ceiling payment rate should be.

More specifically, rate setting entails three fundamental steps:

- Defining allowable costs and the subject service elements,
- Considering present provider costs by these cost elements, and;

- Monitoring the resulting rates to assess their aggregate impact on the system, especially with regard to budget goals (e.g., cost neutrality).

Phase 4: Implementation

Implementation requires careful reflection and planning.

1. With assessment levels established and expenditure amounts associated with each IBA/LBA, it is time to step back and review what has been learned. Establishing predetermined expenditure amounts (which should operate more frequently as caps as opposed to floors) obviously has ramifications for people with developmental disabilities and for service providers. For example, some states have revised their expenditure amounts only to experience unanticipated increases in overall expenditures. In some of these states, this has led to suspension of new enrollments in the HCBS waiver to avoid expenditure overruns. Other states have experienced serious disruptions in their provider networks as a result of rate restructuring, causing negative consequences not only for providers and their staff but also for people with developmental disabilities. It is critical that great care be exercised to ensure that the revised reimbursement rates and/or payment levels do not result in major disruptions of the services and supports upon which people with developmental disabilities and their families rely day-by-day. The state must develop the capacity to anticipate and analyze the effects of proposed changes. In particular, it is important to simulate the results of the new payment structure, secure information about how funding patterns will change, and obtain feedback about the real-world implications of the change. Having ongoing involvement of stakeholders will be helpful in this effort.

2. The provider reimbursement rates that are used in developing IBAs/LBAs may or may not be graduated to take into account differing intensities of support needs exhibited by waiver participants, or other factors influencing the delivery of services, such as how difficult individuals may be to serve, and their geographic location. There may be policy preferences pertaining to allowed indirect expenses, with a possible emphasis, for example, on allowed expenditures for staff training or health insurance. Initial prototype service rates are subsequently reviewed and revised as warranted. IBAs/LBAs must be reconciled to the state budget, accepted cost assumptions, rate and reimbursement rules, state and federal policy decisions, and possibly local budgets to finalize the personal budget allocations. The budgets individuals are awarded must be sufficient to purchase the services they are meant to pay for. Waiver service providers need to be reimbursed appropriately for the approved services they deliver. In any case, care must be taken to set LBAs or IBAs to achieve stated policy goals, but in a way to minimize dislocation for individuals. States must be aware as new allocations are set, some individuals will have increases or reductions in the amount they are assigned. It is important to have appropriate transition plans in place for those affected.

3. A plan must be developed to implement the new policies and practices across the system. This will likely entail modifying administrative rules, building awareness

among individual and providers, training staff and other stakeholders who are key to the implementation process, developing individual service plans, revising billing and payment practices as needed, and otherwise assuring smooth implementation. In addition, state staff should be prepared to use "exceptional care/cost" procedures to accommodate individuals who have unique support needs and do not fit within the established cost allocation model. Any model, after all, is a "best fit" solution to accommodate most individuals and will likely not be satisfactory for all.

4. The new practices are now ready to be implemented. State staff must work with waiver recipients, their families, service providers and others to see that new procedures and decision rules are put in place and monitored over time, so that adjustments can be made as necessary. Experience reveals that several iterations are typically needed before the new allocation system becomes an accepted, integral part of the overall service system. During the "transition" period, the state agency may find it necessary to mitigate the near-term financial impact of the new structure on providers as well as on individuals.

Overall, the process is a challenging one, dealing with the uncertainty of what the data will present as well as the sensitive dynamics of the situation on the ground. It is not a process which can be rushed. Each state is different. The basic approach must be to follow the data and actively engage all stakeholders.

Ten Major Policy Questions/Issues to Consider

Looking at the budget allocation efforts undertaken by the eight states noted earlier, we identified ten common issues or questions that states encountered, at various stages of the IBA/LBA development process. These particular questions were selected for a number of reasons, including: (a) they are common across states; (b) they span the preparation, data collection, budget development and implementation phases of any effort; (c) they demonstrate that no single response is required to move forward in developing individual or level-based budget allocation models; and (d) when considered in advance, they can smooth other states' efforts toward reform.

These ten questions are illustrated below, according to their placement in the process of developing and/or implementing a resource allocation model.

10 Major Policy Questions/Issues to Consider

PREPARATION	DATA COLLECTION & BUDGET DEVELOPMENT	IMPLEMENTATION/ MAINTENANCE
1. What goals are important to establish before embarking on IBA/LBA development? 2. What factors influence the choice of a tool to measure support needs? 3. For budget development, is full population data or a random sample better to achieve the established goals?	4. What cost/expenditure data are states using to build budgets? 5. What can be done to improve the relationship between assessed individual support needs and resulting allocations/ expenditures? 6. How are states developing budget models when they have more than one HCBS waiver? 7. How do budget models accommodate individuals with exceptional care needs and related costs?	8. How often should states reassess support needs? 9. How should states roll out their assessment-informed resource allocation models? 10. What should states do when new people are added, state budgets are reduced, and there is a need to keep rates current and reconcilable?

1. **What goals are important to establish before embarking on IBA/LBA development?**

Essential to moving forward in developing a more rational and equitable resource allocation system is establishing a firm foundation for the work within the larger context of the state's overall goals for its developmental disabilities service delivery system. Improvements in the resource allocation model can serve a variety of goals, and can figure strongly in a wide array of desired system scenarios. States' goals reflect the pressures they are under both internally and externally, the characteristics of their current service delivery environment and the interplay of interests among key stakeholder groups. These factors can be viewed from a short-term and a long-term perspective, with the two intertwining to create a complex and sometimes conflicting set of expectations. The more clarity that state policymakers can bring to the fore, the smoother will be the development and ultimate implementation of the new resource allocation model.

The following state examples illustrate the types of pressures – from federal authorities, state leadership, and advocacy voices – that lead to a common commitment to reform the approach to waiver resource allocation. All of these states set defined policy goals at the beginning of the process.

Oregon

In early 2004, the state developmental disabilities leadership, located within the Department of Human Services, Seniors and People with Disabilities (SPD), recognized that the time had come to restructure its 25-year old "slot-based" system with a new system that would establish individual budgets for some 3,800 individuals and standardize rates for services delivered. SPD sought and received a $2.44 million, five-year federal System Transformation Grant. The project, "Restructuring Budgets, Assessments and Rates" (ReBar), is helping Oregon to develop and test a new funding mechanism that will support desired improvements in Oregon's system of comprehensive services for children and adults with developmental disabilities. Stakeholders established the following specific criteria for the new resource allocation system:

- Meet the critical needs of individuals by tying funding to the individual's needs, maintaining the ability to respond to changing needs and circumstances, and enhancing the person-centered planning process with choice among services and providers;
- Distribute resources equitably, using the same standards and process for all people, such that the resource decisions differ according to individual differences in needs;
- Enhance the capacity and flexibility of Oregon's provider network by supporting diversity and giving providers the opportunity to retool and refocus;
- Enhance credibility and understanding by making the decisions about each individual's supports and funding consistent and explainable;

- Control costs within total funds available by improving the system's capacity for planning and budget projection and by spending resources more logically, wisely, and predictably.

In seeking federal support for its reform effort, Oregon proactively addressed pressures that were building at federal, state and local levels for greater participant direction in the service system. As the developmental disabilities system continued to move away from institutional service options and state resources became more constrained in the face of economic challenges, the efforts to revamp the resource allocation system became an urgent and core concern.

Colorado

The Colorado Department of Human Services, Division for Developmental Disabilities (DDD), and Colorado Health Care and Policy Finance (HCPF) share responsibility for the state's waiver programs to support individuals with developmental disabilities in the community. In late 2005, DDD was questioned by the federal Centers for Medicare & Medicaid Services (CMS) regarding the operation of the Colorado Comprehensive Waiver (HCB-DD). The concerns centered on the state's method of paying for waiver services and attendant problems in ensuring financial accountability.

When the state was unable to demonstrate how its rate and payment structures comported with Federal statute, CMS advised the State it must take immediate steps to establish a direct link between waiver services provided and payments to the agencies supplying the services, or otherwise address the numerous statutory and regulatory issues identified. This change forced DDD to abandon its quasi-block funding arrangement through private community-centered boards (CCBs), effectively unraveling the waiver payment/waiver management architecture put into place in 1999 through the state's System Change initiative. The amount of waiver funding authorized for each waiver participant would now be based on the service plan developed for the individual.

In addition, CMS required that Colorado develop uniform rates for all waiver services (with the option for making those rates variable by support needs of individuals or geographic considerations), such that all providers would receive the same rate for the same service for individuals with similar needs. Colorado faced numerous statutory and regulatory problems with the previous funding structures of the CCBs. The State was presented with numerous options, including seeking managed care authority, to address these issues. In 2006, CMS approved an interim tier approach for the HCBS-DD waiver as a temporary measure until a uniform rate setting method could be finalized. Then, in 2007 DDD contracted with HSRI to develop resource allocation models for both of its HCBS waivers for individuals with developmental disabilities, to ensure that they aligned with federal CMS Medicaid requirements; in particular, HSRI was enlisted to assist Colorado in addressing the CMS requirements for uniform rates which could be tied to a consistent method for assessing the intensity of need.

Rhode Island

In late 2007, the state of Rhode Island began to experience a severe decline in public revenues, leading to intense discussion of public service cutbacks. At the same time, at the behest of the new Governor, the state Developmental Disabilities Division (DMHRH/DDD) began to explore with federal CMS officials the potential for transitioning to a Global Waiver encompassing Rhode Island's eleven Medicaid waivers. As the economic downturn worsened and the state faced the highest unemployment rates in the country, DDD scaled back its Medicaid reform plans and, in 2008, approached HSRI to help improve its HCBS Waiver program, specifically to make the reimbursement system more equitable and efficient.

The original intent of the project was to develop an *exploratory prototype* for an individual budget pilot reimbursement system for its Comprehensive HCBS Waiver, as part of preparing for Rhode Island's transition to a federally approved Global Waiver. The state is still anticipating that this work is the beginning of a multi-year process to develop a valid, rational reimbursement model applicable to the entire Medicaid waiver service population. However, the Governor has acknowledged that the reductions in state retirement benefits and subsequent exodus of thousands of veteran state managers have challenged the state to finish the work necessary to move to the new Global Waiver.

Virginia

The Virginia Office of Intellectual Disabilities Supports (OIDS), in the Department of Mental Health, Mental Retardation and Substance Abuse Services, has worked steadily over the past few years to more fully integrate the principles of person-centered planning into the overall developmental disabilities service system. Building on this intent, in 2007 OIDS broadened its reform effort to include HCBS Waiver resource allocation methods. Virginia's "MR Waiver" supports individuals with intellectual disabilities in the community. By tying individual-level budget decisions to individual needs, state policymakers saw the opportunity to carry forward into Medicaid fiscal planning the self-direction values already driving individualized service planning activities. Crucial to the success of this endeavor was constructing a cooperative relationship with the state Medicaid office and OIDS, wherein both parties recognized the advantages of having a more rational, equitable and efficient decision-making model for resource allocations. Virginia began this process by working with HSRI to design a *prototype* system for assigning Comprehensive HCBS Waiver recipients to one of six Waiver reimbursement levels – allowing time for all parties to become comfortable with the modeling approach, before moving forward in 2008 to develop a full-population allocation system.

Louisiana

In 2005, the Louisiana state agency responsible for developmental disabilities services, the Office for Citizens with Developmental Disabilities (OCDD), began to consider options for improvements in its HCBS Waiver programs. The impetus for this initiative was the rapid increase in expenditures for the 7,000 people currently served, the waiting list of approximately 10,000, and the relatively high spending levels for new waiver participants. How could 2,013 people who had recently

acquired state and federal funding to leave the RFS Registry List (the state waiting list) move to the NOW waiver without rapidly expanding cost? State political leaders were very concerned about the financial impact of the expanded waiver population in coming years. The existing NOW waiver group had doubled in cost during the previous three years and that increase had placed significant strain on state resources. In direct response to this pressure from leadership, OCDD contracted with HSRI and Burns & Associates to develop an exploratory prototype of a reimbursement system for its NOW HCBS Waiver. In order to better calibrate their NOW waiver for stability, fairness, and understandability, and to simultaneously move the service system toward assessment-informed person-centered planning, OCDD began to work with HSRI to explore broader use of the SIS as a resource allocation tool, especially for the authorization of the NOW waiver Individual Family Support and Attendant Care Services hours. OCDD decided to use the project as a test-run for revamping its entire NOW waiver reimbursement system.

2. What factors influence the choice of a tool to measure support needs?

An essential step within the process is choosing an assessment tool to measure an individual's needs for supports. When deciding on a tool, states are faced with several factors and ensuing policy decisions. Such factors often include: (a) the overall cost associated with using a tool, (b) whether or not a state wants to use a home-grown legacy tool or use a new tool, (c) the overall reliability and validity the tool can offer, and (d) the ability for the tool to work within the state's current cultural framework.

States have opted to use different approaches to handle this decision about measurement tools. Some factors, such as cost, are a leading factor for many states, while other factors, such as whether to use a legacy tool, can be moot if the state does not have one. Florida and Rhode Island are examples of states with legacy tools. Florida has a tool in place, the Questionnaire for Situational Information (QSI), which it plans to use in its model for developing individual budgets. Rhode Island has the Personal Capacity Inventory (PCI) which it will face off against the Supports Intensity Scale (SIS) before making a final selection of measurement tool. Other states have looked into and are moving forward with the SIS or the Inventory for Client and Agency Planning (ICAP). These two tools are used nationally, have been tested for several types of validity, and have been nationally normed. However, both may cost more to administer and maintain than the use of a legacy tool that had been developed within the state.

Another factor for consideration is the capacity to apply the tool to individuals across the state's developmental disability population. That is, the tool must be usable for different age groups, for individuals with differing levels of need and ability. This alone can be a make or break point in the state's ability to move forward. Ultimately, state leaders must take into account each of these factors before making a decision.

Colorado

As mentioned earlier, Colorado contracted with HSRI to re-develop their assessment and allocation process for the state's two Medicaid waivers. However, prior to

developing the model, the state asked HSRI to do an examination of fourteen assessment tools[4], to enable the state to choose the most reliable and "best-fit" tool for its population and current service delivery environment. Among the tools studied were the Colorado Assessment Tool (CAT) and the SIS. Although the state had already developed the CAT, and had assessed individuals using the tool, they decided to move forward using the SIS. The factors driving this decision included the tool's ability to measure individual support needs and the desire to use a tool that had been nationally normed.

Florida

Unlike Colorado, who moved away from a state-developed tool, Florida made the decision to use their home-grown tool, the Questionnaire for Situational Information (QSI), when developing the state's new resource allocation model.

The QSI is a questionnaire containing several scales designed to "gather key information about a person that will describe his or her life situation for the purpose of planning supports over a 12-month period." The QSI is part of a broader process to develop support plans that includes the preferences of the individual as well as information from other sources (QSI Version 4.0, p. 2). The tool has been used since 2008 to assess over 35,000 individuals by 75 QSI administrators hired and trained by the Agency for Persons with Disabilities (APD). Administrators are trained using a 19-page *Training Manual* and a 36-page *Administrative Guide* that provide guidance on how to conduct interviews and obtain information.

To ensure the tool's validity, in the fall of 2008 APD conducted a reliability and validity study, which included four psychometric studies on the QSI, as well as a study comparing results from the first section of the QSI with Section One of the SIS. Upon the QSI being deemed a valid tool, the state has continued its use, and has begun looking forward to its potential use for resource allocation. These studies (psychometric, validity, reliability) are critical when deciding to move forward with a legacy tool in developing resource allocation models.

Oregon

In Oregon, every step of the system restructuring process was discussed extensively within the chosen Stakeholders Group. The state's process entailed meetings with stakeholders to outline essential criteria for the selection of an assessment tool. The American Association on Intellectual and Developmental Disabilities (AAIDD) made formal presentations to state leaders and stakeholders on the SIS before Oregon's leadership decided to adopt the group's recommendation to use the SIS.

Following the tool selection, in 2007 Oregon conducted a pilot test using the SIS. An assessment interview was conducted with a statewide random sample of 400 Oregon residents of adult group homes and apartments, individuals in supported living, and individuals using employment and community inclusion services. Pilot test SIS interviews involved the individual, service coordinators, family members and

[4] Smith, G, & Fortune, J (2006). *Assessment instruments and community services rate determination: Review and analysis. HSRI*. Portland, OR.

providers. As Oregon moves forward, it is satisfied with its decision to utilize the SIS to measure individual support needs.

3. For budget development, is full population data or a random sample better to achieve the established goals?

Eventually, new assessment practices and rates must be implemented for all HCBS participants. To start, however, a representative random sample may be drawn to work from. If this approach is taken, means for assessing the impacts of changed practices and rates must be tested against the larger population. Field-tests may be used to probe at such impacts. Where there is already a strong relationship between assessed needs and service costs, systematic field-tests may be very useful. At the least, field-tests would help identify and smooth out logistical difficulties. Of course, larger samples would increase the certainty of the results.

To contrast, policy makers may decide to include the entire population from the beginning or soon after initial analyses are completed on a sample. While this approach requires greater investment at the outset, it makes for more reliable analyses of potential risks and impacts. This approach is highly recommended, especially where there is little or modest relationship between assessments and expenditures or service hours. In fact, in most (if not all) states, this is the likely circumstance and preferred strategy.

Colorado, Florida, Georgia and Missouri – Full Population Data

Four of the eight states -- Colorado, Florida, Georgia and Missouri -- decided early to collect cost and assessment information on all waiver recipients. It makes sense to do this, because if the new assessments and individual budgets or level-budget allocations are going to be used across the waiver, it will eventually require information on the entire group of recipients. In this context, there is no reason to delay matters through a piloting process. Using the full population, however, does require a greater investment at the beginning.

Louisiana, Oregon, Rhode Island and Virginia – Sample Population Data

Other pioneer states such as Louisiana, Oregon, Rhode Island and Virginia have collected sample data and used pilot tests with different levels of formality. It is understandable that a state might want to start data collection with a sample, to “get a toe in the water”, to see if the ideas are feasible politically, financially, and practically. Rhode Island chose a random sample of everyone served (which includes about 3,200 waiver recipients and 400 state recipients), knowing that everyone served might be included in their new global waiver at a later date. Louisiana, because of extensive hurricane damage, began with data from everyone in the capital region, and then added a statewide representative random sample to gain an understanding of the statewide population. Virginia began its effort with a sample of convenience, working through organizations and individuals and families who volunteered to try out the SIS. Later, this proved to have been an awkward starting point; the sample allowed the development of a prototype set of resource allocation levels, but its non-random-sample foundation created many reservations

and cautions about its representativeness. Virginia acknowledged these limitations and responded by deciding to assess the entire state population.

4. What cost/expenditure data are states using to build budgets?

Provider reimbursement rates for waiver services can be standardized or could be based on some combination of legacy factors. These factors could include provider budgets, provider cost settlements, negotiated rates, or legislative priority (e.g., providing dollars to support individuals returning to their home communities from institutional care). For the goals of equity and portability, it is essential that provider reimbursement rates be based on a standard framework or methodology that produces rates based on the level of direct staff effort necessary to deliver a particular service to people. In some states providers are paid different rates for similar or identical services, and a movement toward standard rates will have an impact on what reimbursement providers will receive. States that do not have standardized payment rates can either engage in a rate setting process or can use standardized rates only for the preliminary determination and evaluation of IBAs/LBAs, and consider rate setting in the future.

It is central to an IBA/LBA framework that a state's payments for services ensure that each provider of a service receives sufficient compensation to support the delivery of necessary services to each individual.

The standardized provider reimbursement rates themselves can be graduated, or not, to take into account differing intensities of support needs exhibited by waiver participants, as well as other potential factors e.g., policy preferences pertaining to allowed indirect expenses, expenditures for staff training or health insurance for staff. Existing prototype or proxy provider reimbursement rates are reviewed and revised as warranted to reflect policy decisions. Policy makers, for example, may consider what amount of dollars should be nested within a rate to cover staff training, staff benefits (e.g., health insurance, retirement) or other administrative costs.

Colorado

Colorado used historical expenditures to build support levels for its comprehensive waiver. The state tried using allocated waiver dollars on the SLS waiver to build a cap system, but found that the use of the most recent historical expenditure data based on claims worked best in two ways. It provided more explainability (22.3% instead of 18%) and was more fiscally conservative (average annual cost of $14,095 instead of $15,764). The state also did extensive rate work and some cost studies. However, to achieve budget neutrality in the face of state fiscal limitations, Colorado had to reduce its comprehensive waiver rate structures, to 75% (or less) than the comparable national rates (provided by Navigant Consulting). The economic situation in Colorado's future is not encouraging and additional reductions in funding could loom. The full impact of the downward pressure on rates and the decisions that have resulted is not yet clear.

Georgia

Rather than using historical expenditure data, Georgia used the new fiscal year's authorized allocations (pre-HSRI-developed IBA model). This allowed them to take advantage of a small state increase in the 2009 state budget, and use the dollars allocated to the system to help minimize the negative impacts of the IBA model created for the state's new comprehensive and NOW waivers.

Louisiana

Louisiana used historical waiver expenditure information in concert with examining 127 individual service packages, surveying the hours of paid support being used, along with the hours of natural support provided by community, family and friends. The state also considered whether the individual had shared living opportunities and access to a day program. Importantly, the state found that two groups were quite different, and thus it built a level-based budget model based on whether the individual lived at home with family; or lived in the community with shared living opportunities or in their own home.

Oregon

Oregon used historical waiver expenditure data, which has grown increasingly individualized over the past three years, from the state eXPRS payment system. In addition, Oregon triangulated that historical cost information with a survey of types of services and supports, a survey of the direct service hours provided in each type, and a comprehensive survey of organizational costs and income related to providing services in 37% of the state waiver service provider organizations. These surveys of costs and income included all revenue streams. Using these three sources of information allowed the state to resolve conflicts in the incoming informational streams.

5. What can be done to improve the relationship between assessed individual support needs and resulting allocations/ expenditures?

A central issue in using the SIS for resource allocation decisions is the relationship between an assessment of need (using SIS scores and perhaps other complementing variables) and historical waiver expenditures (or planned waiver allocations or service hours). When developing a resource allocation algorithm, the goal is to establish the highest correlation between SIS scores and expenditures. In essence, the greater the correlation, the greater the variance explained, and thus the greater the confidence in using a measure of support need like the SIS scores to establish individual budget allocations.

In exploring the factors that best predict a state's historical waiver allocations, HSRI uses a method of regression analysis called entry style regression, with SIS scores and other variables loaded into the regression model first, followed by residential setting or living arrangement and other factors. In general, a reimbursement model built on the SIS explains something less than 50% of the variance in expenditures under a comprehensive waiver. By contrast, the highest explained variance reported

in the literature for CMS utilization review of medical procedure utilization is 28%; more often it is on the order of 20% of explained variance or less[5].

In most states where HSRI has worked, a few key predictor variables have consistently proven to have face validity as well as a significant role in explaining statistical variance of waiver expenditures. Among the many SIS variables, three constructs commonly appear to have explanatory strength. The "ABE score" is the support needs of an individual in three specific areas of the SIS -- Part A: Home Living Activities, Part B: Community Living Activities, and Part E: Health and Safety Activities. The total SIS 3A Medical score is the intensity of exceptional medical supports that a person needs. The total SIS 3B Behavioral score is the intensity of exceptional behavioral supports that a person needs.

In addition to the SIS data, two other types of information typically play an explanatory role. First, whether or not the individual poses a community safety risk may explain about 10% of the variance in the relationship between assessed need and expenditures. Second, including the individual's residential setting or living arrangement variable also explains considerable variance. Settings differ somewhat across states, though they are generally classified by size and level of independence given to the individual, differences which in turn are related to expenditures. Adding these factors may double the amount of explained variance[6].

One dilemma presented by the use of residential setting in the regression concerns the value of personal choice. While residential setting often contributes substantially to explaining the variance in resource allocation, doing so may "lock in" a budget allocation for the individual tied to his or her present residential setting. As a result, though the added predictive power may be reassuring to policymakers and providers, this power is lost if or when the individual chooses a residential setting different than the one currently used. This implies the need for developing separate allocations based on living arrangements, and developing state policies governing the degree of freedom individuals have to change (and be funded for) living arrangements.

The range of explored variance in HSRI SIS reimbursement models varies from 22.3% in the SLS Colorado four-cap support level model, to the 75.3% Georgia individual budget model. Generally it is more difficult to explain variance in support waivers than in comprehensive waiver reimbursement models; similarly, children's individual budgets are more difficult to explain than adult results.

A few state examples illustrate the varied paths followed in seeking to maximize the explanatory link between individual support needs and expenditures.

Colorado

Colorado's reimbursement model for the Comprehensive waiver reached 51.5% explained variance using SIS information and one other factor. This is a remarkable

[5] Diehr, P., Yanez, D., Ash, A., Hornbrook M., Lin, D. Y.,(1999). Methods for analyzing health care utilization and costs. *Annual Review Public Health*, *22*, 125 – 144.

[6] In both Oregon and Virginia, adding a measure of community safety risk and residential facility size almost doubled the amount of variance explained in the model.

accomplishment because the Comprehensive waiver model was initially built in the midst of variations among Community-Centered Boards (CCBs) in different parts of the state, reflecting differing county waiver payment rates. In arriving at custom-made reimbursement levels, HSRI incorporated DDD's intent to make the new provider reimbursement system using support levels independent of both CCB location and residential setting.

In initial efforts to explain the variance in historical expenditures, HSRI found CCB membership and types of living arrangement to be most powerful. Since funding levels varied considerably CCB-to-CCB, it was not surprising to find that CCB was the strongest predictor. A somewhat less powerful but still significant predictive variable was type of living arrangement. For example, all other things being equal, payments tended to be lower for people served in host homes than in group homes or other apartment settings. Colorado explored the possibility of indexing by geographical location but state Medicaid authorities decided not to do so because this approach is not used for any Medicaid services. [Virginia, by contrast, is considering this geographic modification because it is a factor in its Medicaid state plan reimbursement.]

Unlike other states, Colorado from the start wanted to revamp its reimbursement approach, moving toward self-directed waiver allocations at the same time as it created assessment-informed provider reimbursement. This meant building the new waiver reimbursement system without reference to residential setting or geographic location. So HSRI *built around* the CCB and living arrangement factors, creating assessment levels that grouped people appropriately in terms of support needs anchored in historical allocations. Left for the later rate setting process was determination of precise dollar amounts, at which point cost differences among residential settings could be more accurately and appropriately accommodated. Designing level reassignment based on SIS results corrects Colorado's prior payment tiers which were not well-aligned with assessed support needs.

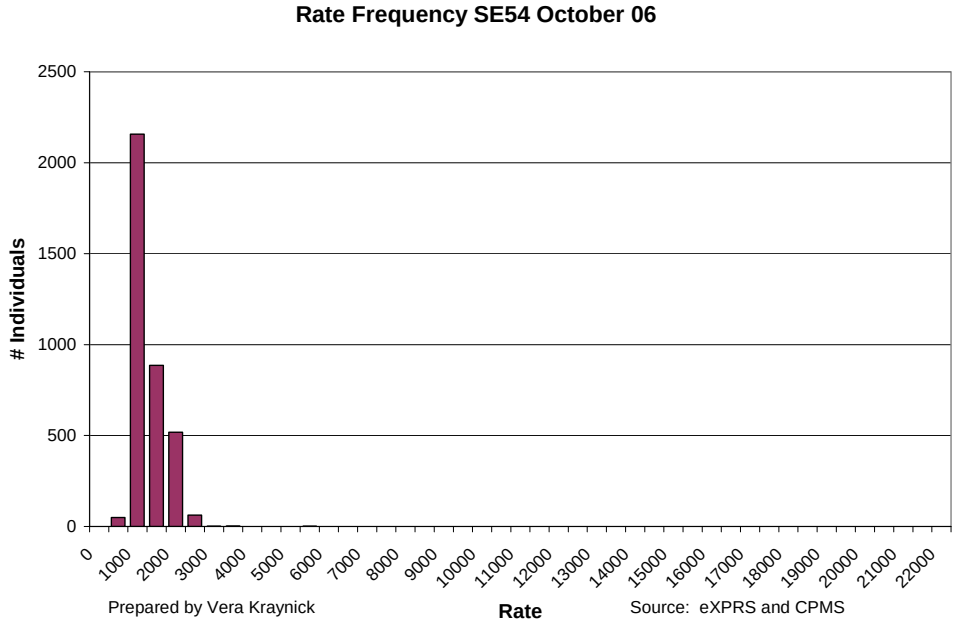
In HSRI's final analysis of the full population dataset for the Comprehensive waiver, four specific factors emerged as the most statistically significant in explaining variances in payment amounts: SIS ABE score, SIS Section 3a Medical Support Needs, SIS Section 3b Behavioral Support Needs, and Community Safety Risk. This last variable accounts for people who have either been convicted and pose a current safety risk, or have the same extreme behaviors such as murder, fire-setting, rape, or pedophilia, and were not convicted. The question is designed to identify just the individuals who present more serious,current, community safety risk. This group of people may include 2-5% of individuals served. This factor was introduced by Colorado and has since been found to be a powerful explanatory factor in many other states.

Oregon

Over four years, Oregon has very gradually increased the amount of variance in expenditures that can be explained. Since the ReBAR project began in 2004, the state has been able to explain increasing percentages of its waiver reimbursement. Initially, the percent of explained variance in adult residential services expenditures

was, at the best, 18%, reflecting the fact that there had never been a systematic matching of financial resources to individuals' support needs. Federal lawsuits, residential deinstitutionalization, and the ups and downs of state budgets created a reimbursement legacy system that everyone agreed needed to be transformed. The blending of dollars by payment groups[7] tended to create a murky relationship at best.

A glance at this 2006 integration and employment SE54 service element chart shows that most of the service recipients have three main prices ($1,000, $1,500, and $2,000) covering all but 115 people of 3,676 Oregon waiver participants. Nested and hidden within the integration and employment structure were six specific services (Employment Facility Based, Individual Supported Employment, Habilitation Facility Based, Community Inclusion Group, and Individual Community Inclusion).



In the past it was not clear which of the services were being used in the three main categories of adult residential, supported living, and integration and employment programs. The emergence of the eXPRS system waiver payment system in Oregon gradually began to more closely associate dollars with individuals. Also, the use of SIS-informed assessment levels, plus addition of a community safety risk variable enabled the explanatory power to grow to 42.0%. Finally, the use of facility size as a rate variable allowed the state to reach 44.5% of explained variance in adult residential services.

Louisiana

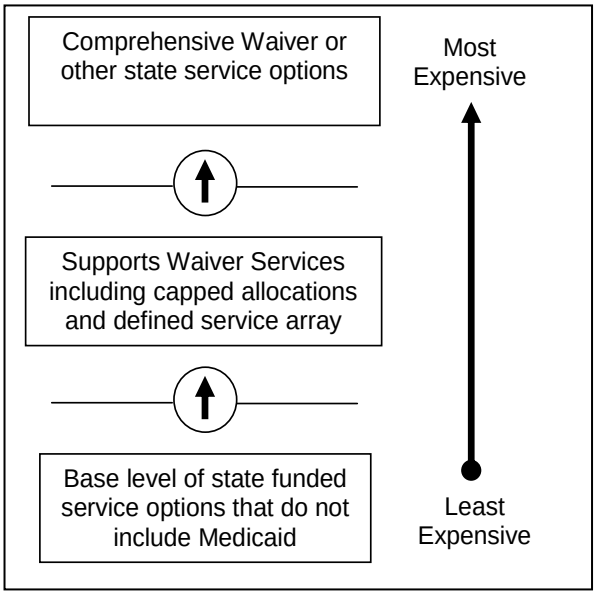
Louisiana has long sought to develop an understanding of how their NOW waiver participants' support needs related to their waiver expenditure for Individual and Family Support and Attendant Care Services hours. Early efforts following a

[7] For example, one county used the identical rate for 100 individuals.

Wyoming Doors type of regression model using individual items from the SIS and from the state's 56-item LA Plus SIS supplemental measures afforded little explanatory power. However, with insights gained from Colorado's similar explorations, Louisiana was able to explain 45.6% of variance with their assessment levels. Specifically, 15.6% of the variance is explained by the SIS results of the people using the waiver (including ABE, Section 3a Medical and Section 3b Behavioral Supports), and 30.0% of the variance is explained by the two types of residential setting.

One dilemma presented by the use of community living arrangement in the regression concerns the value of individual choice. While residential setting does contribute substantially to explaining the variance in resource allocation, this added predictive power is lost if or when the individual chooses a residential setting different than the one currently used. However, in the case of Louisiana the choice of two community living setting models allows individuals and families a choice and allows the state to use the relevant reimbursement model. Living with a family member versus living alone is the best predictor of costs/expenditures in the NOW waiver. In the NOW waiver, more variation in costs is explained by this factor than any other. Now equipped with a solid explanation of variance as an informal point of reference, the state has been able to accept 2,013 approved waiver applicants into the NOW waiver services while helping to assure overall budget containment.

6. How are states developing budget models when they have more than one HCBS waiver?



CMS offers states flexibility in the design of their waivers including targeting a population, determining the number of people to be served, and choosing the type of services. A pattern of "supports waivers" has emerged across the states wherein currently, 18 states operate separate "supports waivers." Supports waivers operate side-by-side with the traditional "comprehensive waivers" that provide more extensive services, including licensed residential services furnished outside the family home.[8] Supports waiver programs do not offer residential services and are characterized by a relatively low dollar cap on the total amount of HCBS services that may be authorized on behalf of a beneficiary. As a result, the per waiver participant cost in comprehensive waivers is

[8] Smith, G., Agosta, J. & Fortune, J. (2007). *Gauging the use of HCBS support waivers for people with developmental disabilities*. Washington, DC: Office of Disability, Aging and Long Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation.

substantially greater than in supports waivers. Several states such as Washington, Oklahoma, South Carolina, and recently Florida, operate separate tiered waivers that provide increasing support by using, for example, four waivers that work in tandem to increase the support provided to a person depending on which waiver is used.

Aside from this cost advantage, recent changes in federal policies have also prompted states to set up separate supports waivers. Specifically, in 2001, CMS issued a State Medicaid Director Letter #01-006 (a.k.a., Olmstead Letter #4). This letter addressed the question of whether a state could operate a single waiver program which restricted the benefit package that certain waiver enrollees were eligible to receive. CMS made it clear in the letter that this practice is barred by federal Medicaid law. In essence, the letter was intended to prevent a state from administering what is termed a "waiver within a waiver" – that is, a waiver that was internally partitioned to control the number of people who could access certain types of waiver services, typically 24-hour, out-of-home residential supports. The letter made clear that, once a person is enrolled in a particular waiver program, that individual must be able to obtain any service that is available through the waiver, if they need it.

Colorado

Colorado, the first state in the country to develop a supports waiver, began work developing a new comprehensive waiver resource allocation system in 2006 due to pressures from CMS. The resource allocation work completed around the comprehensive waiver[9] helped the state develop a more equitable and ample system for moving forward. This work also helped to spawn similar work on the state's supports waiver (Supported Living Services waiver (SLS). The state sought assistance from HSRI to develop a model for the SLS waiver that followed the same framework of support levels, under common methodology, as the model used by the comprehensive waiver. HSRI thus took similar steps to what was done in the comprehensive waiver: once SIS data was collected for individuals on the SLS waiver, HSRI worked to develop a model similar to the six support levels in the comprehensive waiver, using the same SIS predictor variables to develop the support level assignment criteria. Notably, by using the same framework for both waivers, the state had positioned itself so that an individual moving from the supports waiver to the comprehensive waiver could do so more smoothly. The following two tables show how the state transitioned from six support levels to four capped support levels.[10]

9 For more detail, the reader should review: Kimmich, M., et al., Developing Individual Budgets and Reimbursement Levels Using the Supports Intensity Scale. (2009), HSRI. Portland, OR.

10 In the spring of 2009 Colorado is doing further analyses of updated expenditure data and minimum service levels before finalizing the dollars associated with each cap.

Support Levels	People	Average	Median	Minimum	Maximum	Std. Deviation
1	1,111	10,818.34	$10,200.38	$226	$35,000	$6,115.01
2	705	14,866.92	$14,279.00	$392	$35,000	$6,976.68
3	210	18,040.14	$17,434.39	$838	$35,000	$8,006.21
4	150	18,172.71	$17,723.61	$1,545	$35,000	$8,490.51
5	176	18,820.56	$18,685.87	$733	$35,000	$9,054.32
6	177	18,751.74	$19,340.75	$72	$35,000	$9,735.29
Total	2,529	14,094.97	$13,131.16	$72	$35,000	$7,876.06

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.

Georgia

In contrast to Colorado, Georgia did not develop two models to encompass the census of individuals in the waiver system. Instead, due to the state's work to develop an *Individual* Budget Allocation framework, all individuals were encompassed in a single individual budget model.

This framework was unique in the sense that though all individuals were within the statewide model, there were still two waivers housed within that model. This type of model was made possible and less expensive, in part, by the state's relatively low use of out-of-home placements. To develop separation between the two waivers,

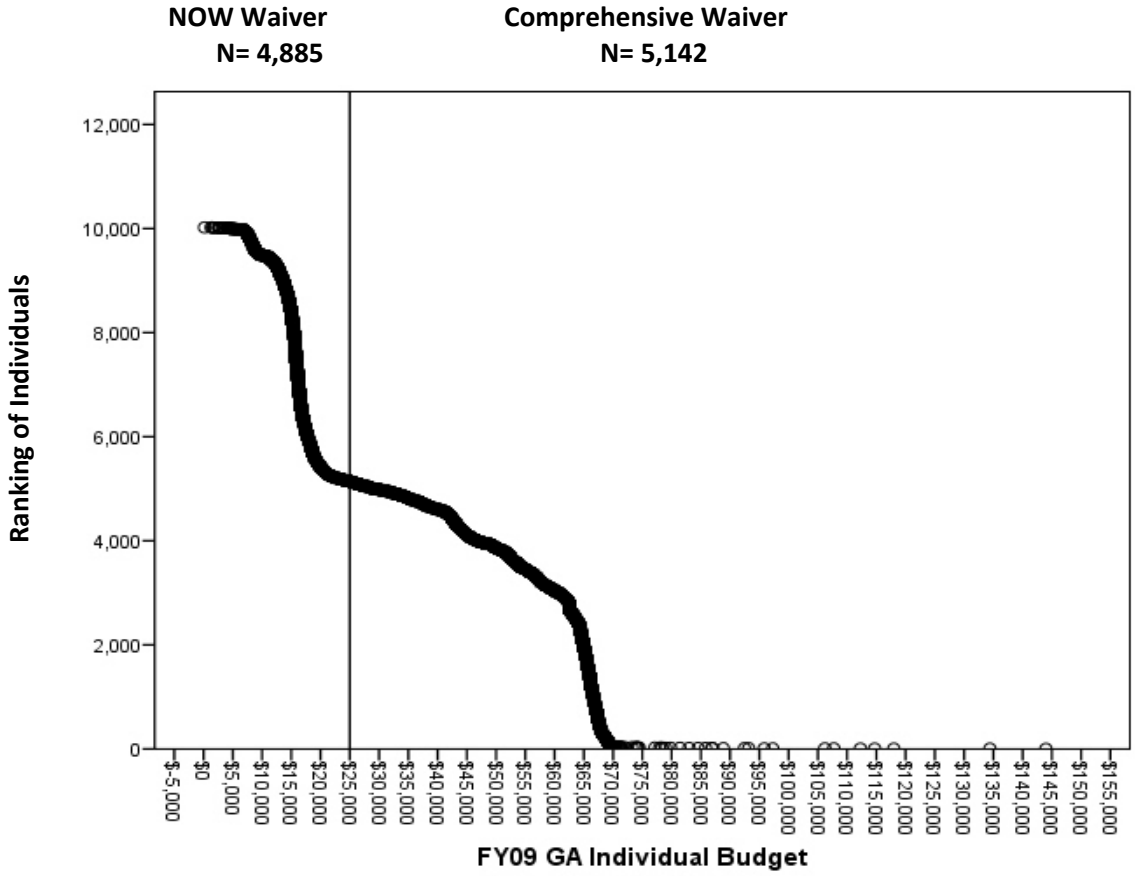
parameters were set wherein individuals whose budgets exceeded $25,000 annually, signaling the need for 24/7 residential care, were placed onto the comprehensive waiver, and those with less severe needs were placed on the supports waiver. The graphic below illustrates the ranking of 10,027 waiver recipients by their individual budget allocations. It also shows the number of people served by each waiver (NOW = 4,885, Comprehensive Waiver= 5,142).

The graphic reveals two key findings:

- Nearly half of the individuals have modest budgets of $25,000 or less while relatively few individuals have budget allocations over $70,000.

- Georgia has established a tiered approach that allows the two waivers to work together so that individuals with fewer needs are served within the NOW Waiver and those with greater needs are served within the Comprehensive Waiver.

Ranking of 10,027 Individuals and their Individual Budget Allocations for Fiscal Year 2009 by Two Waivers



Florida

In contrast to both Colorado and Georgia, Florida developed four separate tiered waivers. The tiered waivers replaced Florida's existing waivers (Developmental Disabilities (DD) waiver, the Consumer Directed Care Plus waiver (CDC+), and the

Family and Supported Living (FSL) waiver) with four new and separate "tiered waivers." The dollar amount associated with each tiered waiver, is displayed below.

WAIVER TIER	WORKING DEFINITION
One	No annual expenditure limit is legislated for participants assigned to Tier One (with the most expensive individuals in the former Comprehensive waiver).
Two	Total annual expenditures under Tier Two may not exceed $55,000 per individual.
Three	Total annual expenditures for Tier Three may not exceed $35,000 per individual.
Four	Total annual expenditures under Tier Four may not exceed $14,792 per year (the former Supports Waiver).

These tiered waivers offer a systematic approach for placing people into the appropriate "tiered waiver" that matches their support needs to a dollar amount to pay for those supports. The state plans to develop IBAs for members currently in all four tiered waivers using the Florida Questionnaire for Situational Information (QSI).

7. How do budget models accommodate individuals with exceptional care needs and related costs?

Assessment-informed resource allocation models depend on building a strong predictive relationship a between measured individual needs and expenditures. The resulting relationship provides a "best fit" statistical solution for most, though not all, service recipients. Most often, individuals with unique support needs and associated extraordinary costs will not easily be accommodated within the model.

Individuals may fall outside the model for a variety of reasons. In a few instances the model may call for an individual to receive a larger budget allocation than is needed. This circumstance concerns policy makers because it could represent over-spending that should be reined in. In contrast, a budget allocation may be far less than what a person requires. In such instances, there is concern that a smaller budget allocation could jeopardize the individual's well-being. Finally, where historical expenditures are used to help craft budget amounts, some individuals may be allocated extraordinary amounts simply because that is the amount that was agreed upon in the past.

Regardless of the circumstances, it is important to assure that individuals are assigned budget allocations to match their needs, no more and no less. In this context it is essential to acknowledge that there are always a number of individuals who legitimately are not reasonably assigned financial resources using even the best systematic assessment-informed resource allocation model. Even when done well, an allocation model will not work for every waiver recipient.

As a result, for these individuals the cost model must be set aside to address their needs more appropriately. To do so, an exceptional care and cost group must be developed. We estimate that states may expect to have about 7% of individuals with

exceptional care and cost needs that fall outside the best-fit allocation model. Higher percents are possible but likely reflect a less than optimal cost model that accounts for fewer people and/or relatively high numbers of people with high historical costs.

States may address the issue in several ways.

- Develop ways to identify and separate individuals whose needs and associated costs are extraordinarily different (often higher) from others. In New York[11] and in Oregon[12][13], the SIS has been shown to have value in identifying people who cost more than other.
- Develop rules and procedures, and designate staff to handle the process for adjusting or making exceptions to the IBA/LBA based on participant health and welfare needs or other factors specified by the state. Any criteria that are applied to adjust the budget are clear and explicit.
- Develop waiver safeguards that come into play when the amount of the limit is insufficient to meet a participant's needs.
- Convene a committee to review exceptional care and cost. It is not uncommon for states to call the committee which deals with this "an exceptional care and cost committee to consider individual circumstances one at a time to develop new budget amounts.
- Notify participants of the amount of the limit to which their waiver services are subject and to which services the limit applies.

States may choose to:

- Adjust individual budget allocations to raise or lower the allocation as warranted. Few would complain about their budget allocation being raised, but lowering an allocation may well prompt complaint. States should be well prepared to defend any adjustment and to assure that the individual's needs are addressed.
- Decide to leave high allocations unchanged, even if the allocation is not warranted. Some individuals may have been previously awarded a high allocation, and policy makers may elect to maintain its level without adjustment.
- Remove any individual deemed to have extraordinary needs and associated costs from the budget model. Doing so would make it clear that these individuals are exceptions whose needs must be carefully documented and addressed. These individuals may represent a long term and perfectly valid exception to an otherwise useful and reliable resource allocation system.

[11] Wehmeyer, M., et al. (2009). Efficacy of the Supports Intensity Scale (SIS) to predict extraordinary support needs. *Intellectual and Developmental Disabilities*. *114(*1), 3-14.
[12] Fortune, J., Chiri, G, Smith, D. (2008). Formation of two groups of exceptional care. *HSRI Information Brief*. 1-6. Portland, OR.
[13] Fortune, J. & Agosta, J. (2008). Determining DD50 Exceptional high care and cost status using selected ReBAR SIS & supplemental questions as red indicator flags. *HSRI Information Brief*, 1-8. Portland, OR.

Colorado

After losing a federal lawsuit concerning Medicaid fair hearings in January 2008, Colorado has built in an extensive system for individuals to appeal their assigned support levels in their new comprehensive waiver resource allocation system.[14] The resource allocation model in Colorado initially called for six assessment levels. To accommodate those who did not fall neatly into one of the six levels, a seventh tier was established to hold just these individuals. This group currently includes 130 individuals. The state continues to work with its comprehensive waiver rates and will completely reexamine the exceptional level (Interim Tier 7) by July 1, 2009.

Florida

Florida recently established four separate tiered HCBS waivers. Service recipients are placed into one of the four tiered waivers depending on review of their circumstances. That is, those with higher support needs and/or more expensive more needs are placed into higher-tiered waivers. The state took about five months to examine individuals and made some individual adjustments when circumstances and the needs of the individual warranted changes. The state completed appeals of those decisions in about three months and, in January 2009, won a federal lawsuit filed by Florida's Protection and Advocacy agency objecting to these changes. The state continues to have fair hearings and funding appeals. State staff report that in 2003 Mercer Consulting speculated that if Florida moved to an individual budget system it might have as many as 20% of its waiver participants as outliers. This is due, in part, to rapid waiver expansion in the past ten years and a historic lack of the systematic application of assessment-informed resource allocation.

Oregon

Oregon carefully reviews each resource allocation assignment and has gone to considerable length to consider individuals who might have extensive 24-hour supervision needs due to hurting others, medical needs, or causing injury to themselves. The state has a standing tier review committee which carefully reviews each level assignment and requires extensive substantiated documentation for individuals with exceptional care needs. The state has reviewed 350 individuals in this way since rolling out in November 2008.

Georgia

In the Georgia population, the average Waiver user had a historical annual allocation in FY08 of $37,012, with the least expensive person costing $62. The group also included eight people who cost more than $100,000.

The Georgia individual budgets managers use a CMS-required process to review such cases and, as appropriate, reserve some dollars to pay for these exceptional or extraordinary support needs. Individuals in Georgia whose resource consumptive patterns caused them to be assigned a new individual budget that was significantly

[14] Colorado's procedures can be seen on the Internet viewed on March 15, 2009 at: http://www.cdhs.state.co.us/ddd/PDFs/Update_Support_Level_Workgroup_Assigned_Levels_Dispute_Resolution_Process081208.pdf

different from their prior allocations were identified as outliers; they constituted 6.7% of the state waiver population. Their current waiver allocations were not changed.

8. How often should states reassess support needs?

States, as they complete their first round of assessments with the SIS or other tools, are faced with the question of how often they should reassess individual participants. Reassessment is part of the continuing effort necessary to update the explanation of current waiver expenditures informed by current support needs.

The decision about how often to reassess a decision is influenced by the cost of reassessment, but also by judgment over how much individual support needs change over time. Where resources are a concern, policy makers may decide to reassess less often than they might otherwise. Yet, the complete cost of assessment using the SIS and building a resource allocation model is often less than a fraction of one percent of the total waiver service. Likewise, where support needs are thought to be stable there may be little call for frequent reassessment.

Policy makers, however, do value information to help track changes in support needs and related service costs over time. Such information provides a foundation for projecting future needs and expenditures, aiding overall strategic system planning. As a result, most states choose a three-to-five-year cycle to interview individuals again.

Colorado

Colorado plans to administer the SIS every four years and intends to use the models for a decade, realizing that improved models may one day be possible. Colorado will maintain the needed expertise, state monitoring, and staffing to routinely assign support levels to new, approved comprehensive waiver applicants and funding caps to new, approved SLS (support) waiver applicants. The state is working on ways to implement these changes in concert with the development of individual service plans.

Louisiana

Louisiana has determined it will use the SIS every four years and uses its own state mainframe computer to accumulate SIS results and extensive supplemental questions called LA-Plus.

Georgia

Georgia gives the SIS every year and believes that frequent administrations help build the support culture among the community providers, individuals, and their families. Georgia has given over 24,000 SIS interviews in the past four years.

Missouri

Missouri is planning three-to-five-year SIS assessment cycle, with state-trained SIS interviewers. The state is also using AAIDD to check inter-rater reliability, and planning to have HSRI monitor the overall consistency of results across providers, interviewers, and counties.

Oregon

Oregon plans on giving the SIS every five years, using a specialized unit of state-funded interviewers. It will take four years to complete the ReBAR efforts throughout the comprehensive waiver's services. The state is making level assignments each day based on the assessments that have been completed in the field the prior day.

Virginia

Virginia has determined that it will give the SIS statewide every four years and plans to update SIS-informed individual budgets intermittently. Virginia is planning to increase its SIS interviewer training and monitoring of incoming SIS interviews to increase the overall reliability and consistency.

9. How could states roll out their assessment-informed resource allocation models?

Initiating a new resource allocation model requires that the state establish an appropriate infrastructure for managing the new methodology. At the least, this includes ways to: (a) assess individuals already in service and others recently enrolled, (b) assign individual budget allocations, including managing those with exceptional support needs, (c) manage, track and archive needs and expenditure data, (d) communicate promptly with individuals, families and service providers, and (e) respond effectively to appeals or complaints.

Most notably, it must be understood that a new resource allocation model will alter how funds are distributed in a service system. Individuals may find that their annual allocations rise or fall. In turn, the changes will affect service providers because the aggregate allocations of the people they serve will likewise increase or decrease. Larger providers may be better positioned to weather such changes because in aggregate it may all even out. Smaller providers, however, may not so easily shoulder funding changes, especially where the majority of their service recipients are assigned reduced budgets**.**

Likewise, individuals receiving altered budgets from their past rewards could decide to seek different services or choose a different provider. We note, however, that even without changes to allocations, individuals still have the option to change service providers.

Overall, shifts in the distribution of dollars will make all parties anxious about the impacts. Regardless of the attention given to infrastructure needs associated with implementation, this plain circumstance must be acknowledged and thoughtfully managed. If not handled well, changing the flow of resources can disrupt a system, provoke significant resistance and ultimately bring to a halt the change process.

To offset the difficulties associated with implementation, states can proceed in a variety of ways. During the early stages of building a new allocation model, states can do much to ease concerns. Working with accurate data on personal needs and expenditures, for instance, lends confidence to the process. In this regard, having information on the full population of service recipients, rather than a sample, allows

the state to plan for potential implementation impacts on individuals and providers across the state. Likewise, meaningful stakeholder involvement helps all to track and give input to the process as it unfolds. Stakeholders may also alert state staff to potential difficulties with the new model. Finally, an unrushed process where IBAs/LBAs are carefully calibrated with sufficient service reimbursement rates will help reduce complaints later.

Beyond preventive measures such as these, states may roll out a new resource allocation model in several ways. Generally, states may implement the new model all at once or phase it in over time. Phasing in a new model can itself take many forms. States may phase in the model with certain cohorts first, say new enrollees, or in certain parts of the state and expand application to other areas over several months. States may also implement a portion of a person's new allocation at first so that it is a mix of the new amount and what the person received previously. With time, the new budget takes hold completely. Regardless of the strategy chosen, policy makers are seeking a solution whereby individuals and providers can reasonably endure and adjust to near-term fiscal impacts.

HSRI has worked with four states that have recently rolled out SIS assessment-informed reimbursement models. Georgia and Oregon rolled their models out in November 2008. Colorado rolled out its model in January 2009. Louisiana is using the reimbursement model as an informal guide and reference to inform support coordinators as 2,013 people joined the NOW waiver beginning in January 2009. In the states that HSRI has worked with, all use some variation of a time-phased roll-out to lessen impacts on people, families, waiver providers, state regions, and the service system overall.

Colorado

Colorado's roll-out schedule was heavily influenced by CMS pressure requiring that Colorado develop uniform rates for all waiver services (with the option for making those rates variable by support needs of individuals or geographic considerations), such that all providers would receive the same rate for the same service for individuals with similar needs. An interim tier approach for the HCBS-developmental disability waiver was approved as a temporary measure until a uniform rate setting method could be finalized. While the initial CMS audit concentrated on Colorado's HCBS-comprehensive waiver, CMS was clear that these changes must be made to all developmental disabilities waivers, including its supports waiver, as the statutory and regulatory problems existed in those structures as well.

Colorado chose to roll out its support level reimbursement system one waiver at a time. New level-based budgets were rolled out for participants in the state's comprehensive waiver on January 1, 2009. The state plans to roll out its cap reimbursement system for the SLS waiver, subject to CMS approval, on the renewal date of the waiver July 1, 2009. The state continuously downloads new SIS results for use in level assignment watchful of CMS renewal dates and state budgetary requirements.

Georgia

In November 2008 HSRI built 10,527 individual budgets for everyone in the state's two new. Georgia has used protected spreadsheets to make 527 new individual budgets during the year to accommodate new waiver applicants. Policy makers elected to phase in the Georgia Resource Allocation System over a period of five years, with 20% of the dollars allocated coming from the model in the first year and increasing in 20% increments in each of the following years, building to 100%, with the remaining percentage of the dollars allocated coming from the historical waiver allocation. The individual budgets are applied ahead of the new waiver service planning meeting which is scheduled on the individual's birthday. This is an important way to phase-in a new system, reducing the immediate impact on many individuals while building support for the longer-term shifts.

Georgia outsources the SIS results to SIS On-line and the development of SIS-based individual budget model to HSRI. Keeping administrative control the state has been careful not to release specific predictor variable weighting information that would allow providers to "game" the reimbursement system by precisely changing SIS results to increase their revenue. [15] There is some risk of this in systems where support coordinators or case managers are employed by service providers and administer the SIS interviews. By not sharing the precise decision rules that form the subgroups, transparency is increased while minimizing the risk of gaming. In a like manner, Georgia has shared the ideas behind the SIS interviews and the resulting individual budget model with a large body of stakeholders many times over the last four years. Providers who do not have precise information and simply score the SIS to portray people as worse than they are stand out when results are monitored by the state.

Louisiana

Throughout 2007 and 2008, Louisiana's Office for Citizens with Developmental Disabilities (OCDD) worked closely with HSRI and Burns & Associates to develop a seven-level resource allocation prototype for its HCBS NOW waiver. The state has chosen to rollout its new budget allocation system in phases. It began by applying the new model to a pilot study group. Then, because the impetus for restructuring the reimbursement system was to manage the movement of people from the waiver waiting list, the state is next addressing the 2,013 people on the waiting list scheduled for entry to the NOW waiver during 2009. Individual desk and clinical reviews were combined with input from all the interdisciplinary teams to see whether the number of service hours suggested by the SIS-informed level system met the individual needs of NOW waiver participants in the pilot group and NOW applicants. Further traction for roll-out was gained through inspection of the adjustments made to service reimbursement rates.

[15] An instructive pioneer Individual Budget System preventative state response occurred in South Dakota when the SBR was implemented in 1996. Small numbers of providers were sitting around kitchen tables using spreadsheet programs to reverse engineer published regression weights to secure better financial results by changing assessment results. The state effectively responded by using a small group of carefully trained state staff still known in the state informally as "ICAP police" to monitor assessment results that influence resource allocation.

This work was shared with stakeholders and policy makers throughout the later half of 2008. Then, equipped with a solid explanation of variance as an informal point of reference, the state has been able to start accepting 2,013 waiver applicants into the NOW waiver services while helping to assure overall budget containment.

Oregon

The roll-out in Oregon features a phasing process that focuses on specific cohorts. The state began with two specific subgroups of their comprehensive waiver.

- The first subgroup included 44 individuals who in 2008 were in residential institutional care at the last remaining facility in Oregon. These individuals had SIS interviews in the summer of 2008 and assessment levels were generated to help inform the funding of their transition plans to the community. Over half of these former residents are now in the community being served by the state's comprehensive HCBS waiver. The final few individuals living at the institutions will transition to community settings in August 2009.

- The second subgroup included 300 individuals currently having the lowest level of reimbursement statewide. These 300 individuals were assessed using the SIS and their waiver resource allocations were aligned with their SIS results. With the results of the SIS, 127 of the 300 people remained at the least expensive assessment level. Importantly, the majority of individuals will receive increased funding related to a closer matching of their support needs with waiver funding. Most of the 300 people (57.7%) moved to higher assessment levels of waiver support. This pattern will not be the same for other subgroups.

Next, Oregon plans to target individuals receiving services in "supported living apartments" and day-time "employment" and "community integration" programs. To do so, Oregon has established automated means for assigning individuals to assessment levels using SIS results administered the day before. This will allow the state to move quickly, one person at a time, to establish new budgets for individuals within the targeted service categories. Using this method, the state plans to implement new budgets for all affected individuals over the next four years.

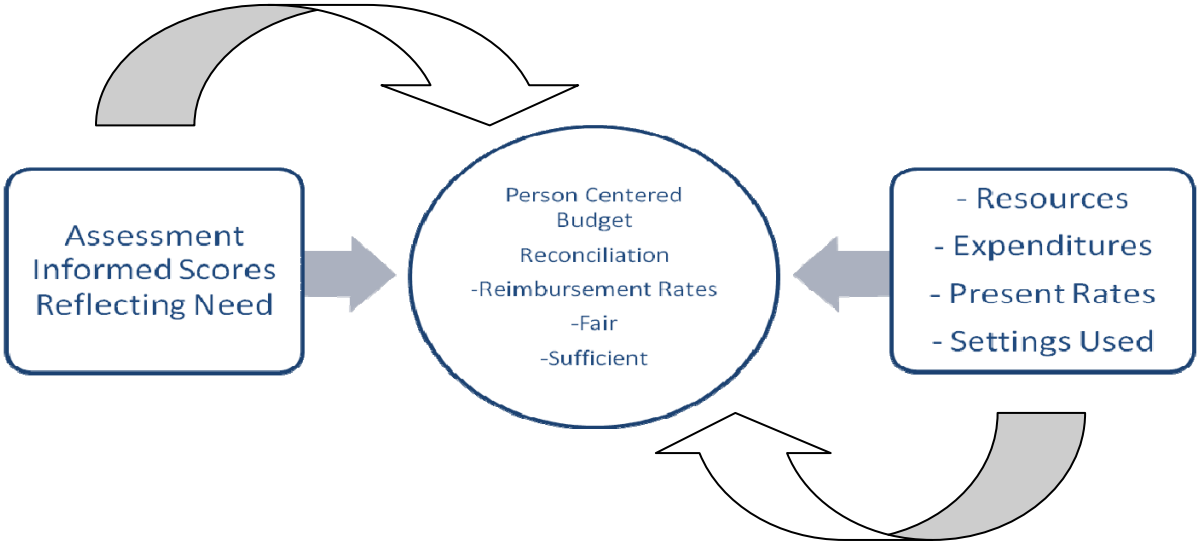
Subsequently, although timing may be altered due to state budget shortfalls, Oregon also plans on phasing in new LBAs based on level assignments for residents of 24-hour living settings, individuals coming into foster care, and adults entering the state's comprehensive service system.

10. What should states do when new people are added, state budgets are reduced, and there is a need to keep rates current and reconcilable?

A number of states have successfully rolled out individual budgets or budget levels. How do they keep them relevant, current and fresh? For example, one immediate practical challenge is how to determine individual budget amounts or assign individual budget levels for new qualified applicants. Additionally, it is essential to

consider what to do when state budgets change, and how to keep the resource allocations current and reconcilable.

In the illustration below, it is immediately evident that the waiver resource allocation model needs to be *perpetually* revisited. It has to include current information about the people in the waiver, refreshed by individualized information that includes the assessment results of the latest qualified applicants. There is a need for periodic adjustments to be made. Most often, this is done on the provider reimbursement rate development side to account for increased costs, decreased state resources, changes in state policy, and new Federal waiver requirements that must be met by states and by local waiver service providers.



One of the most frequent questions that HSRI and Burns & Associates have been asked by states over the past two years is how can they access a national rate book or similar resource. A national rate book would allow states to look over state boundaries and see what rates are being used in other states. Such a resource unfortunately does not currently exist. One valuable resource that many states refer to is the Arizona rate information which is periodically updated and benchmarked, and has been a useful source of rate referral by many states.[16]

It is critical that great care be exercised in the development and review of the reimbursement system, to ensure that the revised rates do not result in major disruptions of the services and supports, or exceed funding constraints. For example, some states have revised their provider rates only to experience unanticipated increases in expenditures. In some of these states, this has led to suspension of new enrollments in the HCBS waiver to avoid expenditure overruns. Other states have experienced serious disruptions in their provider networks as a result of rate restructuring, causing negative consequences not only for providers and their staff, but also for people with developmental disabilities.

[16] Arizona DDD Rate Books are frequently updated but a recent example is located on the Internet at https://www.azdes.gov/ddd/downloads/vender/rates/ratebook_20070701.pdf

The state must develop the capacity to anticipate and analyze the effects of proposed reimbursement changes. In particular, it is important to simulate the results of the new structure, secure information about how funding patterns will change, and obtain feedback about the real-world implications of the change. Having ongoing involvement of stakeholders will be helpful in this effort. For example, a typical early result of the analysis and review for comprehensive waivers is the identification of client living arrangement as a significant variable that explains expenditures. This leads to the division of the comprehensive waiver population into two, or possibly three, subpopulations based on client living arrangements: group home, independent living, and living with family.

Colorado

Colorado used extensive work by Navigant Consulting to build on its comprehensive service level rates that were supported by national research and a local study of costs. These rates were then also used for the SLS waiver when the services were the same. Respite service rates for the SLS waiver were developed after a comprehensive national study of the other 17 CMS-approved respite support waiver rates from other states. Naturally, different community living arrangements have different costs and need different levels of financial support. The number of beds in group homes and the people in those beds influence the dollars necessary to fund a 24-hour 7-days-a-week residential facility. Interestingly, even with extensive work with a well known national firm, Colorado staff and the community rate work group have continued to work for over a year to adjust rates to match current and future budget pressures and the results of ongoing service utilization studies.

Georgia

Georgia used local rate development knowing that 75% of waiver expenses are usually attributable to staffing costs, 15% of costs are often indirect costs, and 10% of expenses can be attributed to administration. One thing that helped keep Georgia's dollars in balance was the limited development of the community service network which puts constraints, for example, on the number of group homes available. Georgia looked ahead to see the impact of its individual budget model on regions, providers, and individual waiver participants.

Summary of Findings

Policy makers increasingly are seeking to restructure state resource allocation practices for individuals with developmental disabilities. They are doing so in response to various pressures (e.g., increasing service demand, budget shortfalls, reliance on legacy services), but are also seeking to achieve greater system *efficiency* and *equity*.

The restructuring process takes steady work over a few years. Information on individual support needs and expenditures per person must be collected and reconciled against present practices to yield new individual budget allocations and, perhaps, changes in provider reimbursement rates. Infrastructure to support the new allocation practices must also be put in place. Inevitably, the new allocations and rates must be rolled out in ways

to minimize system disruption. All along, stakeholders must be involved in ways to help guide the process and keep them informed, minimizing their potential resistance to prospective changes later. A complex change process such as this requires careful planning and deliberation and decision making on countless policy matters that come to define the new system.

This paper examines 10 significant issues that policy makers must consider when developing and implementing individual or level-based budget allocations. The questions spread across the main phases of the process states follow (i.e., preparation, data collection and budget management, and implementation and maintenance). These issues all revolve around the premise that individuals are best positioned to receive individualized services if they have individualized budget allocations.

In this context, the actions taken by the eight states highlighted in this paper illustrate that assessment-informed resource allocation shows promise for assisting to improve the match between individual support needs and available waiver dollars. For example:

- These states defined policy goals at the beginning of the process, in favor of funding that was equitable, designed with the same methodology, fair, explainable, portable, prioritized, and personal. This always included the goal of establishing a more rational and equitable resource allocation system that, in turn, would provide a firm foundation for achieving other systemic goals.
- States carefully chose a tool to measure support needs. In this regard, the SIS appears to be at least as useful as other assessment tools and shows a consistency of results across states boundaries that is useful for forming individual budgets or individual budget levels that meet CMS guidelines. In these states, a number of SIS variables were found to consistently indicate the support needs of individuals. It is also evident that the SIS group results differentiate between support needs for people using comprehensive waiver services versus supports waiver services.
- Four of the eight states chose to use full population information by collecting cost and assessment information on all waiver recipients. The more information that is available the better the opportunity for all stakeholders and state leaders to make the best decisions and projections.
- States used the flexibility that CMS offers to develop budget models in different ways using the waivers they have in place. Georgia offers a particularly interesting example by using the latest waiver application format for two new waivers, building on four years of SIS assessment, and phasing in each new individual budget over a five-year interval. This approach allows individuals to gradually transition toward a better match of their support needs and their waiver dollars.
- States used the flexibility that CMS offers to develop budget models in different ways using the waivers they have in place. Georgia offers a particularly interesting example by using the latest waiver application format for two new waivers, building on four years of SIS assessment, and phased

over a five year interval gently rolling out an individual budget for everyone ahead of their waiver service plan date. This effort helps individuals transition toward a better match of their support needs and their waiver dollars over a period of years and reduces immediate large individual financial impacts.

- All states seek to accommodate individuals with exceptional care and cost needs, although this has been done in a variety of ways. States have also made somewhat varying decisions about how often to reassess support needs, with the cycle of reassessment heavily influenced by the cost.
- States establish and use an appropriate infrastructure for managing the new resource allocation model which includes assessing people's needs, assigning individual allocations, managing, tracking, and archiving needs and expenditure data, communicating promptly with individuals, families, and service providers and responding effectively to appeals or complaints.
- Each of the four states that has rolled out a model has done so by phasing it in using a variety of strategies.
- States have found that adding new people, facing reduced state budgets, and keeping rates current and reconcilable are essential ongoing tasks.

Taken together, these eight states have already done much to restructure their resource allocation systems to make them more equitable and efficient. Still, in these states much remains to be done to roll out the new systems in ways that minimize service disruptions for individuals and service providers. Likewise, after initial implementation, states will need to persevere in maintaining relevant databases and using this information to adjust the allocation models as warranted. Throughout the process, policy makers must make scores of decisions to define the new system, but do so in ways to assure that the system stays aligned with stated policy goals.

Similarly, much still can be learned from the collective experiences of these and other states. Already, decision-making patterns may be observed across states, including the strategies used to address various issues. Moreover, comparisons of data bases across states reveal patterns to describe waiver participants as well as related expenditures. Upon review, study of these findings may be used to guide the actions of any state working to restructure its budget allocation practices.