Wyoming Department of Health
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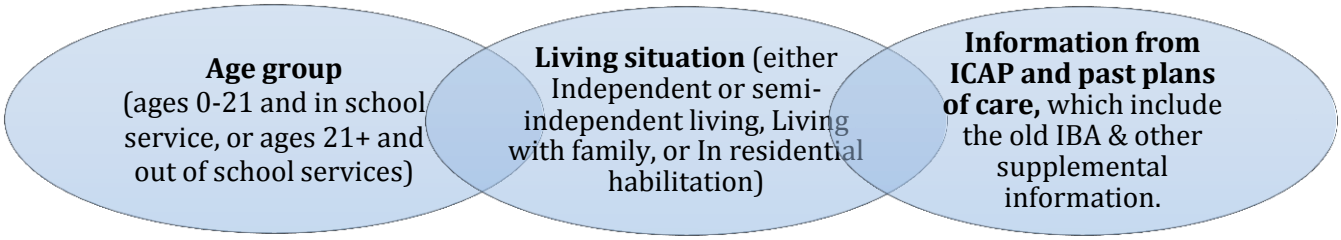
Behavioral Health Division

Understanding the Comprehensive Waiver IBA Methodology

The new IBA method

The Behavioral Health Division (BHD) now uses three (3) factors to determine a participant's new Individual Budget Amount (IBA): the person's age group, living situation, *Inventory for Client and Agency Planning* (ICAP) assessment, and prior plans of care and service utilization. The figure below shows the interaction between these factors. Different living situations require different levels of funding. Participants with more assessed needs and residential services require more funding than participants living at home or living independently. *The Level of Service Need Scoring Rubric,* which includes descriptions of the *Assessed Level of Service Need*, is included at the end of this document.

Budget Development Factors



Process for Determining the Level of Service Need Score

Four (4) steps determine the assessed *Level of Service Need score*:

1. **The first step** converts data on service needs from the ICAP assessment subscores into a continuous scale from 1-6. A continuous scale means that scores may have fractions, such as 2.4 or 4.5.
   - Independent and high functioning individuals are rated between 1-3.
   - People with higher needs are rated between 4-6. <u>All</u> participants receive an initial *Level of Service Need* score.
2. **The second step** converts subscores from the ICAP's *Behavioral* and *Medical domains* into a 1-6 scale.
   - This step will affect the *Assessed Level of Service Need* for some participants because the higher score of the two passes is kept.
3. **The third step** flags individuals with high-assessed medical and behavior service needs, as indicated by the ICAP. This pass increases their final *Assessed Level of Service Need.*
   - This step only affects participants with severe medical and behavioral needs.
   - <u>This step finalizes the *Level of Service Need Score,*</u> which equates to a preliminary budget amount.
4. **The fourth step** caps any IBA change for transitioning participants at ±7% before finalizing the budgets.
   - The algorithm compares the original and preliminary IBA.
   - If the difference is greater than ±7% of their old IBA, then the IBA changes by only ±7% instead of original difference.
   - Therefore, existing waiver participants going to the Comprehensive Waiver are limited to change of ±7% of old budget.
   - The 7% cap limits and contains large IBA changes, eliminating the need for phase in protection.
   - **IBAs will not be phased in.** The IBA changes are a one-time event.

The 7% cap complicates the model, but minimizes the impact to any one participant.

If two people with the same score had different budgets on the Adult DD waiver, the new IBAs with the 7% cap will still show two different IBAs for the same score.

Final Score and IBA

The overall Level of Service Need score assigned is a result of the three (3) passes. The preliminary budget is assigned based on a budget amount associated to the final score. Then, the former IBA is compared against the new preliminary budget.

The new "final" IBA is either more or less than the former IBA, but is limited an increase or decrease of 7%.

New people *funded onto the waiver from the wait list will not be impacted by the 7% cap. They will get a budget that corresponds with the level of service need score assigned. See the table on page 3.*

Discrete Budget Level Development

The waiver application described the basis for the estimates of services and dollar amounts along the level of service need scale. The Division analyzed budget utilization by several different ages and settings to determine estimates of service needed, using average costs and current service rates to build the formulas for each discrete budget level. This resulted in six (6) discreet points for each of the three (3) living situations and two (2) age categories. The final product is a 6X6 matrix, seen on the next page.

Dollar amounts in between these levels are based on the curve that connects discrete levels. Assigning an IBA based on a fraction of a level ensures fairness by not penalizing those who fall close to a rounding point (e.g. a 3.49 being assessed as a Level 3, where a 3.51 is assessed as a Level 4).

For example, for those living with family, the budget for each Level is based on the hourly rate for personal care services multiplied by the estimated required hours of service (daily and weekly) for each tier level. The number of hours progresses at each tier. As the level of service need increases, the hours and days of service needed increase from about three (3) hours a day to three and three-quarter (3.75) days a week on the low end to seven (7) hours a day for five (5) days a week on the high end.

For people living in residential services, the budget for each level is based on the daily residential habilitation rate for each *Assessed Level of Service Need* and a full year of units. Day service budgets are based on an estimated required hours of day services multiplied by the 15 minute Community Integration rate for each Level. Hours start approximately at four (4) hours a day.

Purpose for 7% cap

The goal of the new budget methodology, as established by the legislation, was to develop a fair and equitable distribution of funding and serve more people on the waiver with the same budget. All participant budgets for the Comprehensive Waiver either increased or decreased in comparison to the budget from the other waiver because a new formula was used. Many were affected by only a small percentage. In some cases, participant budgets rose or dropped significantly in the new model. These significant changes were studied closely while the new IBA model and proposed budget levels were made available to the public.

Public comment received on the new approach prompted the Department to consider the use of old IBAs in the model, since they showed an individual's historic need for a certain level of assessed need. In order to minimize the impact to the waiver system and any one participant, BHD settled on using a capping system, which other states have implemented. The 7% cap was ideal for minimizing the impact while also creating savings to fund approximately 130 more people from the wait list over the next two years. In summary, the Department decided to limit any increase or decrease in the new IBA to a 7% change to safeguard any one person from too much of a drastic impact.

Comprehensive Waiver Budget Table to set IBAs prior to the 7% cap

Budget by age and living situation	Level of Service Need 1	2	3	4	5	6
Living at home - under 22 and in school	$12,260	$15,271	$18,281	$21,292	$25,708	$ 48,163
Living at home - 21 and older and out of school	$15,271	$19,285	$23,299	$27,314	$31,328	$ 48,163
Living independently or semi-independently - under 22 and	$20,003	$26,308	$35,629	$35,629	$46,776	$ 121,338
Living independently or semi-independently - 21 and older	$ 28,874	$ 37,397	$ 51,153	$ 54,420	$ 72,102	$ 166,273
Living in residential services - under 22 and in school	$32,665	$35,629	$46,776	$55,057	$71,628	$ 121,338
Living in residential services - 21 and older and out of school	$41,536	$46,718	$62,300	$73,849	$96,955	$ 166,273
Living in a special family habilitation home		All SFHH placements :		$55,057		

Table notes:

- *The budget level chart sets budgets according to the continuous Assessed Level of Service Need score assigned,* ***prior*** *to the limit of the 7% impact cap for current waiver participants.*
- *This chart determines IBAs for new participants, who will not have a 7% cap.*

Examples of How the New Budget Methodology Works

Joe Sample, waiver participant

Suppose that "Joe Sample" is a current waiver participant who will be assigned a new IBA. He is 25 years old and living in a residential habilitation setting. Between the first two passes, Joe Sample received an *assessed level of service need* of **2.68.**

Example 1

- In the first example, Joe Sample has an old IBA of $59,000. The algorithm, account for his age, assessed level of service need, and living situation, assigns a new IBA of $57,497.90. This means that his IBA changed by ($1,502), or by -3%. Joe Sample was not flagged in the system for higher medical or behavioral needs, and since the absolute value of -3% (3%) is less than 7%, his IBA will not be modified in the third pass.

Example 2

- In the second example, Joe Sample has an old IBA of $70,000 and the algorithm still assigns an initial IBA of $57,497.90. The system checks for medical or behavioral flags based on prior assessment information, and determines that he will not be flagged. Then, the algorithm looks at the percentage difference between his old IBA and new IBA. In this case, it is -18%. The algorithm takes the absolute value of (18%) and asks if it is greater than 7%. In this case, it is. Therefore, the algorithm assigns him an IBA of $65,100, which is his old IBA less7% of his old IBA ($65,100=$70,000-7% * $70,000).

Example 3

- Now suppose Joe Sample has an old IBA of $59,000, and after the first two passes is assigned an IBA of $57,497.90. Since the absolute value of the change, up or down, is less than 7%, he was not flagged in the third pass. However, certain questions from prior assessments indicated that he required higher medical needs, and was therefore given a "medical flag" by the algorithm. This result in a small boost to his IBA of .125, which means that his IBA after the third pass goes up to $59,317.71. Since the change from old IBA to new IBA is still less than 7% (in this case, it is about 1%), he will not be flagged for a 7% cap. The end result is a $317.77 increase in his IBA.

***Susie Sampleson**, eligible person on wait list*

Normally, participants on the waitlist are funded to the Supports Waiver. In some cases, however, there are participants with assessed needs in excess of the Supports Waiver. Here is a hypothetical example of one such participant.

Susie Sampleson is 34 years old, and lives with her family. Susie takes the ICAP and the algorithm runs the first two passes. The first pass calculates an *Assessed Level of Service Need* of **1.2**. The second pass calculates a level of **1.3**. The algorithm then would select the greater of the two levels, which is **1.3**.

Let us look at three hypothetical scenarios that might affect the IBAs of those who qualify to go on the Comprehensive Waiver.

Example 4

- Susie is a new participant, who received a funding opportunity. She is coming off the waitlist, and therefore has no old IBA. Susie does not have severe medical or behavioral needs. She will receive an IBA without any third pass modifications. In this case, Susie receives an IBA of $15,895. Please note that her actual IBA is $15,894.07, however the algorithm always rounds up to the nearest dollar.

Example 5

- In the second scenario, Susie is still a new participant, but also received flags for medical and behavioral services. Susie requires additional supports for these needs, so the algorithm adjusts her final IBA of 1.3 in the third pass. For the medical flag, Susie's IBA is increased by .125, and for the behavioral, .125. The third pass increases Susie's IBA to 1.55 (1.3+.125+.125). Her final IBA is $16,823. This is a $929 increase from her IBA before the third pass. Higher adjusted *Assessed Levels of Service Need* will result in higher increases. Had Susie's *Assessed Level of Service Need* been adjusted from 5.0 to 5.25, she would have received an additional $2,500.

Example 6

- Now we will suppose that Susie is not flagged for additional medical or behavioral needs. Instead, Susie is a transitioning participant from the Adult DD Waiver. Her old IBA was $14,000. The algorithm flags her in the third pass as having an old IBA, and compares her new IBA with her old IBA. Her new IBA, $15,895, is greater than her old IBA by 14%. The third pass caps all changes in IBAs at 7%. This means that Susie's IBA will be capped at a 7% increase, so that she will only receive $14,980.

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Level of Service Need Scoring Rubric

Level 1: The person requires few supports weekly due to a high level of independence and functioning compared to one's peers. This person is independent with Activities of Daily Living (ADLs) but may follow checklists as reminders. No significant behavioral or medical issues that cannot be controlled with medication and routine medical care. Person requires minimal support services that can be provided within a few hours per week, and can be left alone in the home or community for extended periods of time.

Level 2: The person requires infrequent care and limited supports daily due to a moderately high level of independence and functioning. Some days may not require any support. Behavioral needs, if any, can be met with medication or informal or infrequent verbal redirection by caregivers, which may or may not require a PBSP. There may be a need for day services and intermittent residential support services to assist with certain tasks, and the person can be unsupervised for several hours at time during the day and night.

Level 3: The person requires limited personal care and/or regular supervision due to a moderate level of functional limitations in activities of daily living, requiring staff presence and some physical assistance. Behavioral needs, if any, are met through medication, informal direction by caregivers, and/or occasional therapy (every one to two weeks). Person does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day. Intermittent personal attention should be given daily for training, personal care, community or social activities.

Level 4: This person requires regular personal care and/or close supervision due to significant functional limitations, medical and/or behavioral conditions. Therapy and medical care may be needed monthly in addition to support from staff. Behavioral and medical supports are not generally staff-intensive and may be provided in a shared staffing setting. Regular attention is needed throughout the day for training, personal care, reinforcement, community or social activities.

Level 5: The person requires extensive personal care and/or constant supervision due to behavioral or medical concerns or due to significant functional limitations concerns, including frequent and regular on-site staff interaction and support. Therapy and medical care may be needed bi-monthly in addition to support from staff. Behavioral and medical concerns must be addressed with written behavioral and/or medical plans and protocols. Support needs are highly intense, but can still generally be provided in a shared staff setting. Staff must provide line of sight supervision and frequent personal attention must be given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

Level 6: The person needs total personal care and/or intense supervision throughout the day and night. Supervision by a sole staff on-site (not shared) must be conducted by at least line of sight, with much of the staff's time within close proximity providing direct support during all waking hours. At times, the person may require the full attention of two staff for certain activities of daily living and in response to certain behavioral events. Therapy and medical care may be needed weekly in addition to support from staff. Typically, this level of service is only needed by someone with intense behaviors, not just medical needs alone. There is no ratio flexibility from the amount approved by BHD in the plan of care. Behavioral and medical supports require written plans or protocols to address support needs.

Questions on the New Process?

We know this new methodology and transition to the new Comprehensive Waiver is complex. The Division wants to help you understand the changes as much as possible. There is more information and a YouTube video on the new budget methodology on the Division's website: http://health.wyo.gov/ddd/index.html.

If a participant or guardian believes the assigned Level of Service Need score or living situation is incorrectly represented in the IBA letter sent, they should contact their case manager who will get in touch with the Division. And as always, participants and guardians may contact the Division if they have questions or do not understand the process.

The case manager may assist with submitting a request to the Division's Clinical Review Team (CRT) as long as the correction/situation meets the CRT criteria. CRT reviews additional assessments or documentation from the team that may support the request. More information on the CRT process and criteria and the IBA methodology is posted to the Division's website: http://health.wyo.gov/ddd/index.html. The request must accompany additional information that the Plan of Care Team does not think the ICAP adequately captures.

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