VAYAHEALTH

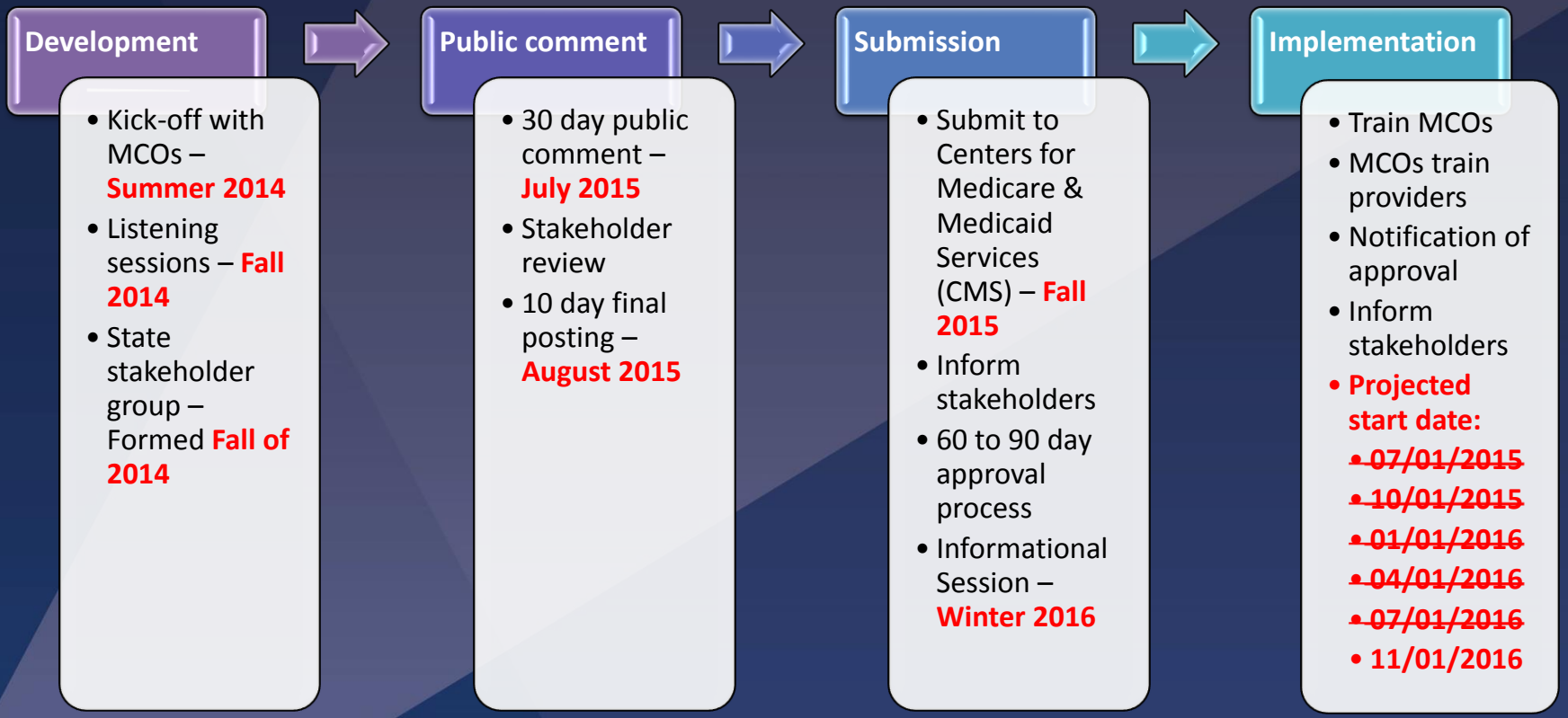
2016 Innovations Waiver Technical Amendment

Presented by:

Robin Winters, PhD, IDD Clinical Director
Jesse Smathers, MSW, LCSW-A, LCAS-A, Director of Network Development

Vaya Health Provider Summit
October 26, 2016

Implementation Date 6.0



Topics

- Resource allocation & individual budgeting
  - ✓ From budget letter to plan approval
- Key points
  - ✓ New services
  - ✓ Changes to existing services
- Service rates
  - HCBS considerations
  - Rates

Types of Letters

- Members will receive a letter explaining individual budget information prior to planning for his/her annual ISP.
  - ✓Letter 1: New to Individual Budget Tool (IBT)
  - ✓Letter 2: Interim – pending expired SIS
  - ✓Letter 3: Missing SIS

Sample of Budget Letter

«First_Name» «Last_Name» and/or Guardian MID #: «NC_Medicaid_Member_ID»
«Guardian_Address_1»
«Guardian_Address_2»
«Guardian_City», «Guardian_State» «Guardian_Zip»

Re: Assigned Individual Budget Category, Level, and Base Budget

Dear Member and/or Guardian:

We are writing you about the above-named member's budget for participation in the NC Innovations Waiver managed by Vaya Health. The State of North Carolina requires people who participate in the Innovations Waiver to have an individual budget. These budgets are a tool to help guide and inform the planning process; not a limit on the amount of services you may request or receive. The budget is based on the amount of services that would usually meet the needs of people with similar support needs. Your support needs are measured, in part, by the Supports Intensity Scale® (SIS®).

The above-named member received a SIS ® assessment on «SIS_Assess_Date». Based on the member's current support needs identified during that assessment, as well as the member's «Residential_Status» living arrangement and the fact that the member is an «adult_child», the Department's vendor (not Vaya Health) determined that the category, level, and base budget that match the member's current support needs are as follows:

Individual Budget Category, Level, and Base Budget:

Year 1, effective «ISP_YR1_Date» «IBT_Locator», with an annual Base Budget amount of $«Phase_In_Amount_Year_1»
Year 2, effective «ISP_YR2_Date» «IBT_Locator», with an annual Base Budget amount of $«Phase_In_Amount_Year_2»
Year 3, effective «ISP_YR3_Date»: «IBT_Locator», with an annual Base Budget amount of $«Phase_In_Amount_Year_3»

Sample of Budget Letter (2)

Please keep in mind that this budget does not include any costs associated with Residential Supports, Supported Living, or non-base budget services; it only covers Respite, Community Living & Supports, Supported Employment, Community Networking, and Day Supports. The member's need for residential and non-base budget services will be evaluated separately from this base budget amount.

The Base Budget and information related to the category and level are guidelines to be used when you are planning for your next plan year. The Base Budget is not a limit on the amount of services you can request or receive. When the Individual Support Plan is being developed, you should discuss with your Care Coordinator the services that are available and that you believe will meet the member's needs. If you believe that the member's needs cannot be met within $«Phase_In_Amount_Year_1», you should request those services that you believe will meet the member's needs. Vaya will review the request against medical necessity and Innovations Waiver criteria, and if we find that the services requested are medically necessary to meet the member's support needs, we will approve those services. If any of the requested services are denied, we will provide written notice, along with information about how to appeal the decision.

If you disagree with your category, level, or Base Budget, you may file a grievance with Vaya Health. Please direct the grievance to:

Vaya Health
Attn: Complaints & Grievances
P.O. Box 1049
Waynesville, NC 28786
grievances@VayaHealth.com
1-888-757-5726

You may file a grievance in person or by phone, email, or mail. For further information on the grievance process, please contact us at **1-888-757-5726**.

If you are new to the Innovations Waiver, please note that this budget and implementation of your ISP will not go into effect until your county Department of Social Services has confirmed the member's Medicaid eligibility for the Innovations Waiver. You should also be aware that continued participation in the Innovations Waiver is dependent on continued Medicaid eligibility. If the member loses Medicaid eligibility for any reason, participation in the Innovations Waiver could be impacted.

Please call Customer Services at **1-888-757-5726** if you have any questions about this letter or about the Innovations Waiver.

Letters

- July for November Birthdays = 107 Clean and 26 with errors = 133
- August for December Birthdays = 118 clean and 1 with error
- September for January Birthdays = 115 clean and 8 with errors = 123

Budget Phase-In

- For individuals who have a history of base budget expenditures significantly more or less than their Individual Budget (IB) amount, there will be a phase in period of not to exceed three years.
- For individuals whose base year base budget expenditures are greater than their IB amount, the phase in percentages are established at 120%, 110%, and 100%.
- For individuals whose base year base budget expenditures are less than their IB amount, the phase in percentages will be established at 80%, 90%, and 100%

Example 1

Example #1- Decrease in Budget:

John is spending $100,000 per year. His IBT is **$80,000**. Over a 3 year period the current spending amount will decrease until it matches the IBT of **$80,000**.

- 1st year 120% of IBT: $80,000 x 120% = $96,000
- 2nd year 110% of IBT: $80,000 x 110%= $88,000
- 3rd year 100% of IBT: $80,000 x 100%= **$80,000**

Example 2

Example #2- Increase in Budget

Jill is spending $50,000 per year. Her IBT is **$80,000**. Over a 3 year period the current spending amount will increase until it matches the IBT of **$80,000**.

- 1st year 80% of IBT: $80,000 x 80% = $64,000
- 2nd year 90% of IBT: $80,000 x 90% = $72,000
- 3rd year 100% of IBT: $80,000 x 100%= **$80,000**

SIS Re-assessments and Addendums

- Request for re-assessment may occur when the beneficiary experiences a major life change (change in health/safety)
- If beneficiary/ LRP has questions/ concerns about SIS results:
  - ✓Contact LME/MCO within 30 calendar days of receipt of SIS score
    - ✓(see Attachment E in CCP 8P for further direction)

Factors that Determine Individual Budgets

- Age (adult vs. child)
- Living arrangement
- Supports Intensity Scale (SIS) scores
- Supplemental questions
- Historical spending
- Best fit model

Budget Categories and Levels

Four categories that make up the Individual Budget Tool

- Non-Residential Child (under 22 years old and living in a private home)
- Residential / Supported Living Child (under 22 years old and living in a group home, an Alternative Family Living (“AFL”) setting or a Supported Living setting.)
- Non-Residential Adult (age 22 and over and living in a private home)
- Residential / Supported Living Adult (age 22 and over and living in a group home, an AFL, or Supported Living Setting)

What are clinical descriptions?

- Each category has seven levels, which are clinical descriptions representative of groupings of individuals who have similar support needs.
- The funding assigned to each level is derived from a package of available services, validated to ensure their clinical appropriateness, that are assigned to each category.
- The seven levels are A, B, C, D, E, F, and G.
- Members always have the option to request services above the individual budget guideline – medical necessity review

What are Base Budget Services?

- Services included with individual budget
- Day to day living services
  - ✓ Community Networking
  - ✓ Day Supports
  - ✓ Community Living & Supports
  - ✓ Respite
  - ✓ Supported Employment.

What are Non-base Budget Services?

- Outside of base budget
- Preventative services, and equipment
- $135,000 waiver maximum budget and base
  - ✓ Assistive Technology Equipment & Supplies
  - ✓ Community Navigator
  - ✓ Community Transition Services
  - ✓ Crisis Services
  - ✓ Home Modifications
  - ✓ Individual Directed Goods & Services
  - ✓ Natural Supports Education
  - ✓ Specialized Consultative Service
  - ✓ Vehicle Adaptations

What if member's support needs cannot be met in assigned budget?

- Intensive review (only base budget services)
  - ✓ Identifies members that are outliers – clinical description does not meet assigned level
  - ✓ Temporary (<6mo.) or permanent
- Medical necessity review
  - ✓ Standard review by clinical operations that requires appeal rights if decision is adverse to the member

Key Points – New Services

- New services – Community Living & Supports and Supported Living
- All other services clarified with intent to increase flexibility
- Gradual elimination of In-home Skill Building, Personal Care, and In-home Intensive Supports

Key Points – New Services

- Providers that are enrolled to provide In-home Skill Building, Personal Care, and/or In-home Intensive Supports will automatically be enrolled to provide Community Living & Supports
- Supported Living will have three distinct levels and shall only be provided in settings that are owned or leased by the member
- Providers that are interested in providing Supported Living must submit a Provider Nomination Form

Key Points – Existing Services

- Community Guide will be called Community Navigator
- Day Supports will be billed at an hourly unit effective November 1, 2016
- Requirement for completion of a quarterly Progress Summary for habilitation services eliminated
- Relative as Direct Service Employee policy changes

Key Points – Existing Services

- The NC SNAP Index Score will not be used to identify Residential Supports levels for members
- Member's receiving Residential Supports in alternative family living (AFL) settings may receive Respite Services
- Primary Residential Supports - AFL direct support professionals shall not provide other waiver services to the member he/she provides Residential Supports - AFL

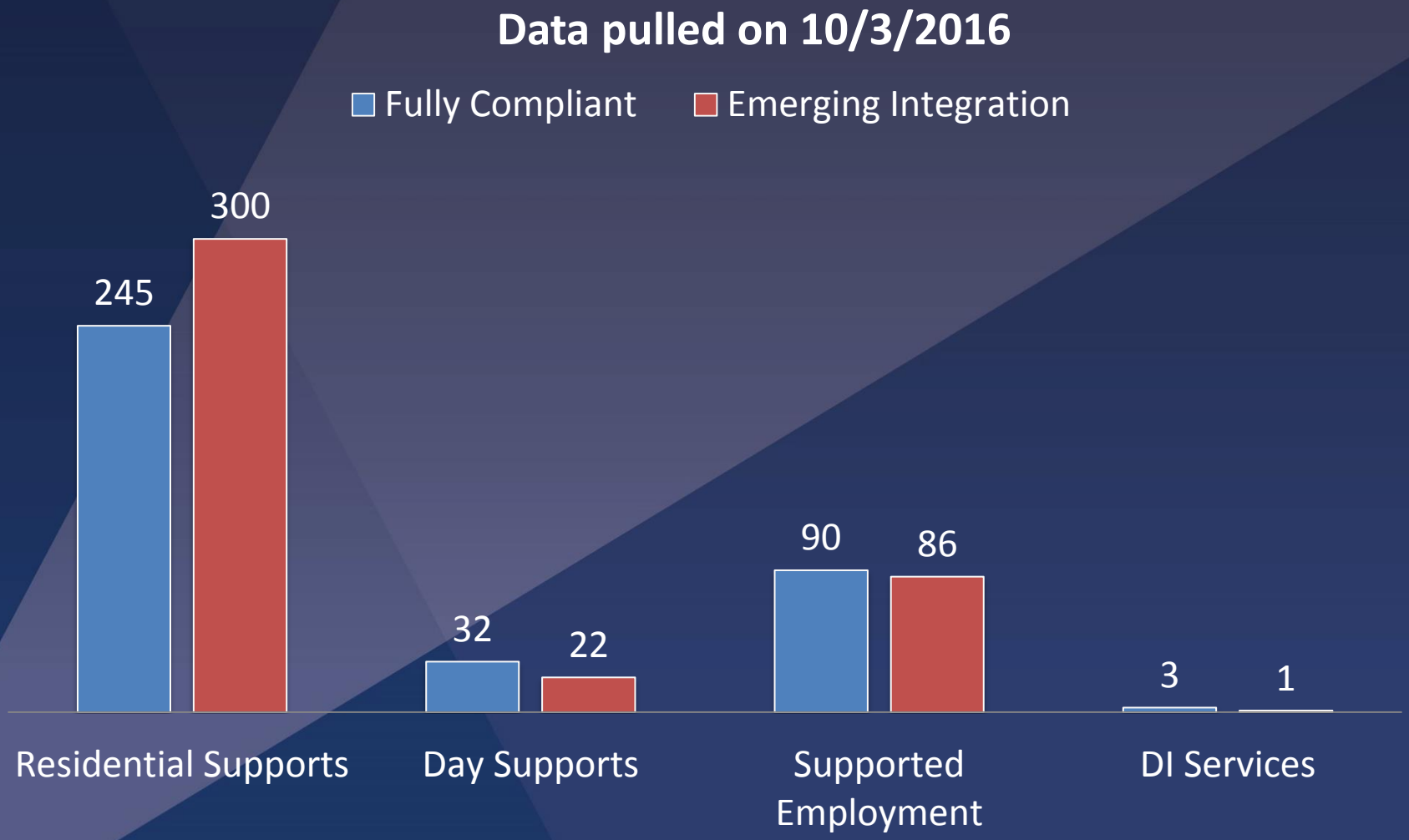
Key Points – Existing Services

- 10 A NCAC27G.5600 Type B & C homes that are currently 3 beds may apply to DHSR to increase bed size to 4
- Newly developed facilities under .5600 may be 4 beds
- There shall be no new admissions to facilities that are licensed for more than 6 beds
- Direct Support Professionals required to meet the CMS Core Competencies within 2 years of implementation

Key Points – Existing Services

- Providers of Residential Supports, Community Living & Supports, and Supported Living are required to have capacity to offer Innovations Primary Crisis Services for emergencies or have a Memorandum of Agreement with an in-network provider of Primary Crisis Services
- Provision of Day Supports, Residential Supports, and Supported Employment must meet HCBS as outlined in the North Carolina HCBS Transition Plan

Total # of Site Assessments = 779

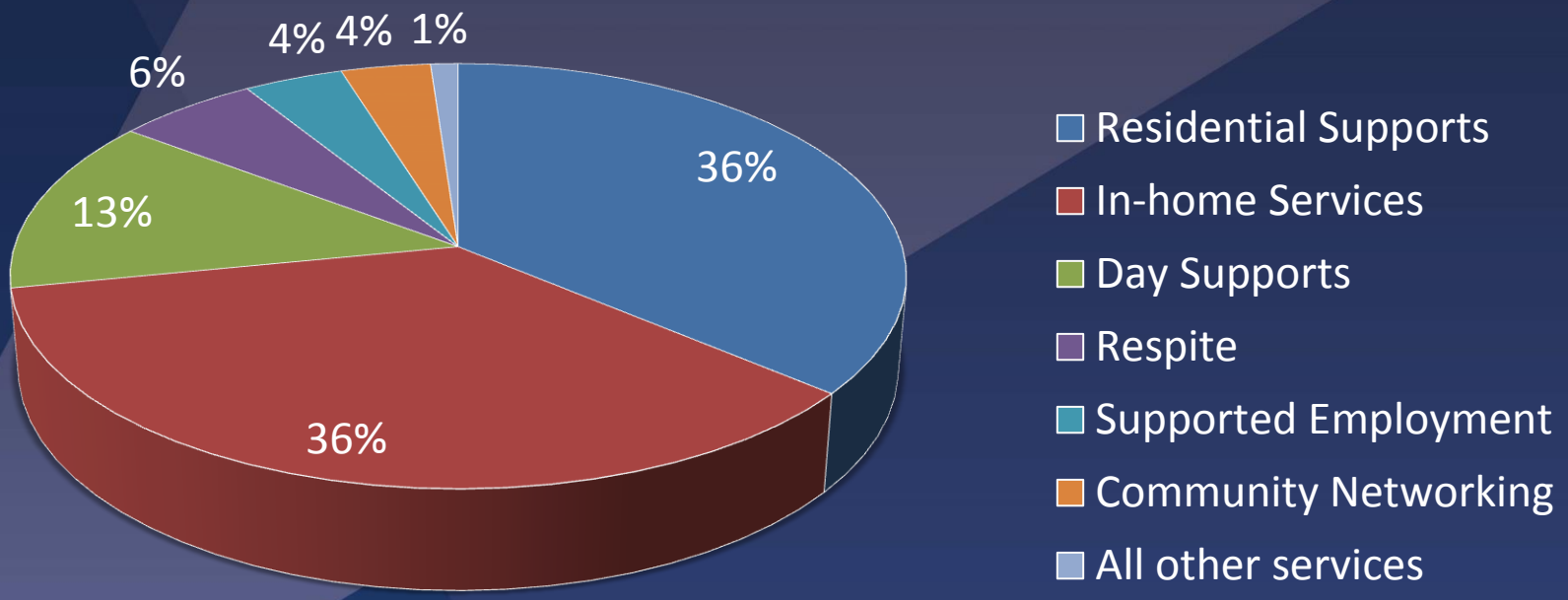


NC: Moving in the Right Direction

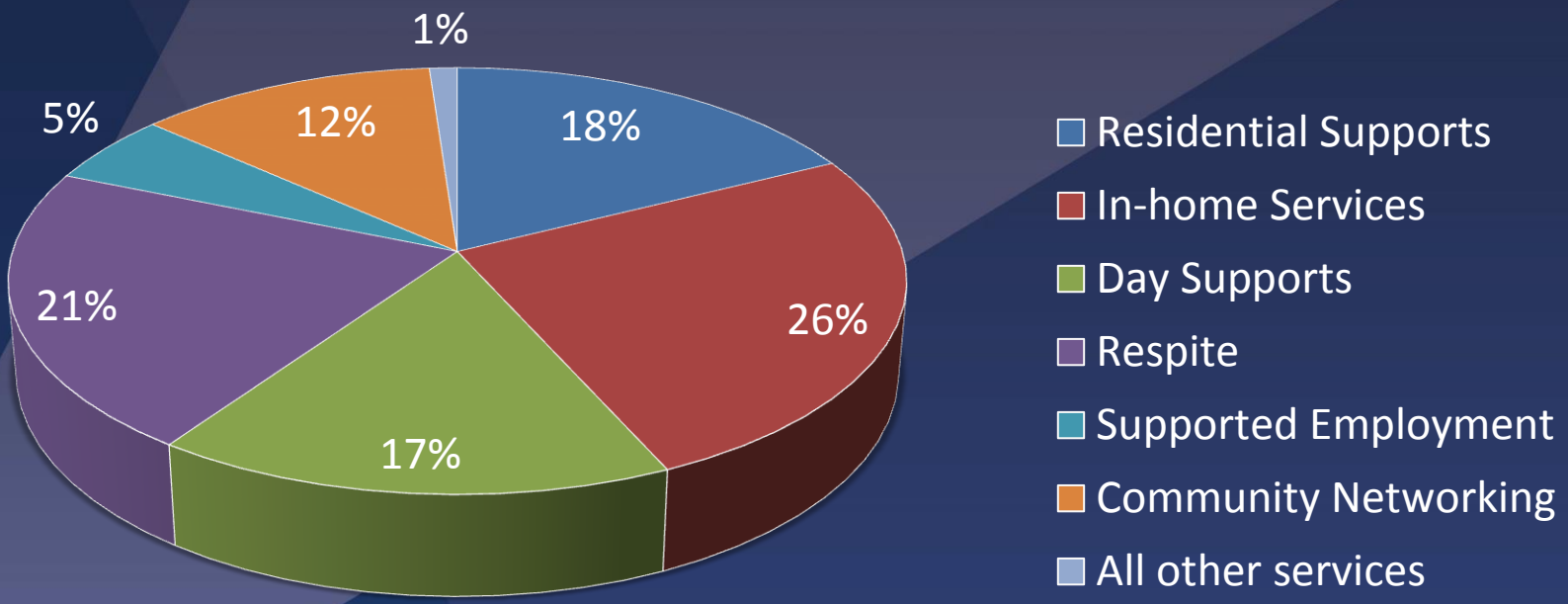
http://happygardenings.com/inclusion-integration-segregation.html

Expenditures by Service

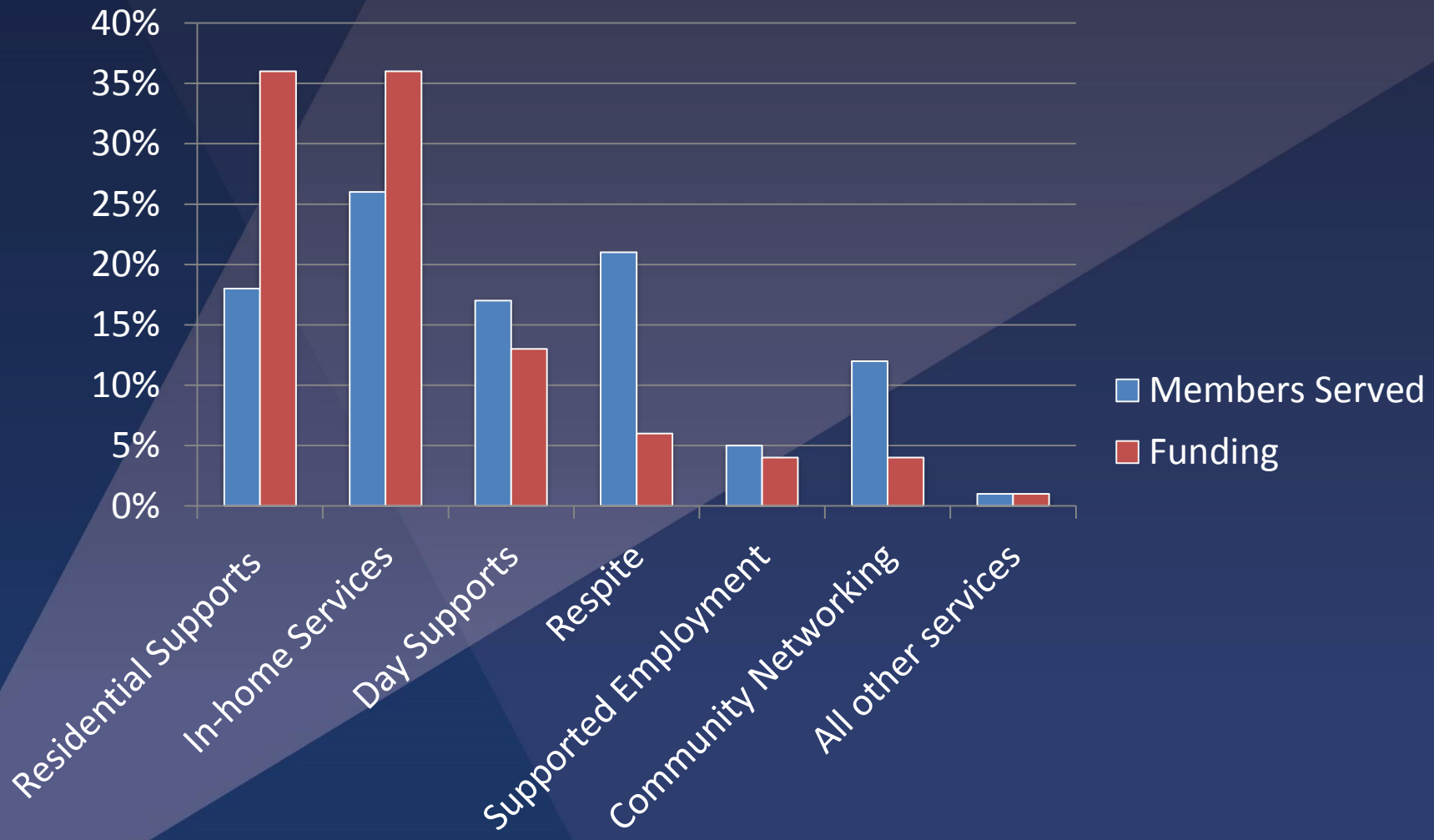
Annual Expenditures



Members by Service



Comparison of % of Members to Funding per Service Line



Rates – New Services

Service	Unit	Rate
Community Living & Supports – Ind.	15-minute	$5.07
Community Living & Supports – Grp.	15-minute	$2.66
Supported Living 1	Day	$152.47
Supported Living 2	Day	$184.09
Supported Living 3	Day	$215.17

Rate Changes – Existing Services

3.13%	6.25%	Other %
Community Networking – Ind.	Community Networking – Grp.	In-home Skill Building (decreased 9%)
Day Supports – Grp.	Crisis Services	Personal Care (46%)
Residential Supports 2 – 4	Nursing Respite	Residential Supports 1 (23%)
Supported Employment – Ind.	Specialized Consultative Services	Respite – Ind. (15%)
		Respite – Grp (10%)

Questions