Using a Resource Allocation Model for I-DD Services

NC Council Spring Policy Forum
June 8, 2015
Why is Resource Allocation important in a managed system (LTSS)?

- A flexible system that ensures resources are distributed in a fair and equitable manner.
- More effective use of funding may assist in moving people off the waitlist.
- A system that empowers individuals and families to purchase services that align with their life goals.
- A system that has a tie between the MCO capitation and the individual budgets.
- A framework that promotes continuous quality improvement from planning to service delivery.
Early Lessons: Support Needs Matrix

2004 Innovations waiver had all the “right stuff”:

• The right vision and values,
• Cardinal Innovations was the NC early adopter of the SIS®,
• Cardinal Innovations used the SIS® to guide the Person Centered Planning process,
• IDD staff in all key managed care roles throughout the company,
• Self direction as a component of the waiver,
• Waiver funding was distributed to each person based on the average cost of waiver services for other individuals of the same age and living situation.
• Two years into operation spending began to increase significantly beyond the capitation.

• The MCO used the typical tools to determine a remediation:
  - reviewed utilization patterns
  - reviewed the rate structure and made adjustments
  - developed additional utilization management criteria
  - requested that HSRI do a comprehensive review of the Innovations operation
What was discovered....

There was limited, if any, correlation between the assessed needs of the individual and the funding they were assigned to meet their needs. There was not a framework to look at the system as a whole, as opposed to just on an individual level.
Actual Expenditures Adult Residential SFY 10

Fair and Equitable
Current Adult SNM Score versus Oct 2009 – Sep 2010
Resources for Individuals in a Residential Setting
Actual Expenditures Child Non-Residential SFY 10

Current Child SNM Score versus Oct 2009 – Sep 2010 Resources for Individuals in a Non-Residential Setting

Support Needs Index (SNI) Score

$0

$20,000

$40,000

$60,000

$80,000

$100,000

$120,000

$140,000

$160,000

150

225

300

375

450

525

600

675

750

Cardinal Innovations
HEALTHCARE SOLUTIONS
What we needed:

• A methodology to determine the individual budget amount for each individual and tie this to assessed support needs to assure that it was sufficient to meet the individual’s needs.

• A system with “safety nets” to customize the funding to ensure that it meets the unique needs of individuals.

• A system to enhance the planning process by adding individual budgets that are aligned with support needs.

• Refocus the Person Centered Planning approval/service authorization process to allow for increased flexibility and allow for customization of funding to address unique needs.
The Cardinal Innovations Support Needs Matrix
Summary of the steps to build the Support Needs Matrix:

1. Engage Stakeholders
2. Complete Assessments
3. Develop Categories and Category Budgets
4. Develop the Matrix
5. Validate the Categories and Budgets
6. Assign the Individual Budgets
Engage Stakeholders

The Innovations Stakeholder Group: The design, implementation and ongoing operation needed to be informed by Stakeholders who understand and live the system “day to day”.

- Formed a Stakeholder Committee.
- The committee was composed of Individuals and Families who receive services through the Innovations Waiver and Network providers of Innovations services.
- The group was nominated by the CFAC and the Network Council.
- There was a commitment by the MCO to collaborate with the committee to inform the development, implementation and continued operation of the Resource Allocation and we continue to meet monthly.
- Prior to the initial implementation, this group met for 18 months, reviewed all aspects of the model, and provided significant input into the final design.
Complete Assessments

• The SIS® is used with Adults and Children (field test) for everyone on the waiver.
• Includes basic support need areas that predict the greatest success for individuals in community settings:
  • Home Living Activities
  • Community Living Activities
  • Health and Safety Activities
• Identifies extraordinary medical and behavior supports which are significant predictors in needs for support.
• Additional Community Safety Risk questions.
• The individual is informed in writing of their opportunity and the process to raise concerns about the SIS® evaluation.
• Five years of SIS data prior to initial implementation to ensure validity.
Categories: to ensure that individuals with similar support needs would be assigned to budgets that would meet their needs.

• Categories are based on assessment data and other factors, cohorts are formed with individuals with similar support needs.
• Categories are not progressive, instead they represent the unique groupings of individuals based on similar clinical characteristics for the actual Innovations population of the LME/MCO.
• Categories are clinically validated against the population to ensure both the description and budget will meet the clinical needs of the individuals assigned to that category.
There are 4 matrices or groupings:

• Children living at home
• Children living in licensed residential facilities
• Adults living at home
• Adults living in licensed residential facilities

Within each matrix there are seven categories labeled A-G that together range from the least to highest support needs.
### Matrices

<table>
<thead>
<tr>
<th>Residential</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>G1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>Minimal Support Needs</td>
<td>Minimal to Low Support Needs</td>
<td>Low to Moderate Support Needs; Behavior and or medical can range from minimal to moderate</td>
<td>Moderate to High Support Needs; Behavior and/or Medical can range from minimal to moderate</td>
<td>Significant physical Support Needs; Behavior and/or Medical can range from minimal to moderate</td>
<td>Extra-ordinary Medical Support Needs</td>
<td>Extraordinary Behavior Support Needs</td>
<td>Community Safety Risk</td>
</tr>
<tr>
<td>Adults</td>
<td>Minimal Support Needs</td>
<td>Minimal to Low Support Needs</td>
<td>Low to Moderate Support Needs; Behavior and or medical can range from minimal to moderate</td>
<td>Moderate to High Support Needs; Behavior and/or Medical can range from minimal to moderate</td>
<td>Significant physical Support Needs; Behavior and/or Medical can range from minimal to moderate</td>
<td>Extra-ordinary Medical Support Needs</td>
<td>Extraordinary Behavior Support Needs</td>
<td>Community Safety Risk</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Residential</th>
<th>A1</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>Children 4 years 11 months</td>
<td>Minimal Support Needs</td>
<td>Minimal to Low Support Needs</td>
<td>Low to Moderate Support Needs; Behavior and or medical can range from minimal to moderate</td>
<td>Moderate to High Support Needs; Behavior and/or Medical can range from minimal to moderate</td>
<td>Significant physical Support Needs; Behavior and/or Medical can range from minimal to moderate</td>
<td>Extra-ordinary Medical Support Needs</td>
<td>Extraordinary Behavior Support Needs</td>
</tr>
<tr>
<td>Adults</td>
<td>Minimal Support Needs</td>
<td>Minimal to Low Support Needs</td>
<td>Low to Moderate Support Needs; Behavior and or medical can range from minimal to moderate</td>
<td>Moderate to High Support Needs; Behavior and/or Medical can range from minimal to moderate</td>
<td>Significant physical Support Needs; Behavior and/or Medical can range from minimal to moderate</td>
<td>Extra-ordinary Medical Support Needs</td>
<td>Extraordinary Behavior Support Needs</td>
<td>Community Safety Risk</td>
</tr>
</tbody>
</table>
• Each category is assigned a “base budget”.
• All people in the category are allocated this base budget which equals their “Individual Budget”.
• In addition, given individual needs, other services may be “added on” to yield a higher personal budget allocation.
• No budget may exceed the $135,000 cost limit for the waiver.
• The Individual Budget is used as a planning guideline, not a limit.
Individual Budget Component

Individual Budget
Not to exceed the waiver Cost Limit

Non Base Budget

Base Budget
Projected Adult Residential Expenditures using SNM

Fair and Equitable Proposed Adult SNM Category for Individuals in a Residential Setting
Projected Child Non Residential Expenditures using SNM

Proposed Child SNM Categories for Individuals in a Non-Residential Setting
This system needs to be “refreshed” every 3-5 years to make sure that the information provides the “best fit” for the individuals in the category.
Improved Person Centered Planning
Resource Allocation is the process that aligns the funding to the Individual Budget. The Individual Budget is a component of the Person Centered Planning Process.
Person Centered Planning Process

• **Discovery** - an exploration of the person’s life goals and dreams; assessments which include the SIS, Risk Support Needs Assessment, Personal Outcome Measures; a discussion of the supports that exist and those that may need to be enhanced and Community Guide Needs.

• **Information to support planning** - an introduction to Self Direction options, information regarding the services utilized in the past year, a review of all of the services available to the person, the individual/family receives the Resource Allocation category and Individual budget information.

• **Meet with partners to plan** - Meeting with planning partners who include providers, Care Coordinator, Community Guide, friends, family members or others that are part of the person’s life.
**Planning: Customized Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate</th>
<th>#of hours/days</th>
<th>Cost</th>
<th>Budget Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td></td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
</tbody>
</table>
The Planning Calculator helps the individual and planning team to visualize the services and supports as they discuss them to ensure that every option the person is interested in is explored.
Plan is drafted with the individual:

- the individual’s request for services inclusive of the frequency and intensity are submitted to Utilization Management for review.
- The person may request services within their budget or services that exceed their budget.
- If the individual or Legally Responsible Person (LRP) does not want to submit a formal request for Intensive Review, the team may submit a plan over the assigned budget amount and it will be reviewed to determine if the services are medically necessary.
The Care Coordinator role in Resource Allocation:

- Scribes the individual’s life goals
- Helps the individual determine through education about service options and assessment the supports that are in place and options to meet the gaps that exist.
- Provides them with their Individual Budget amount
- Uses the planning calculator to explore with the individual all of the service options to determine the “best match” to meet their needs
- Prepares the individual support plan which outlines the services, intensity and frequency that the individual requested
- If additional funding beyond the “base budget” is required to meet these needs, makes the request for a temporary, permanent or intensive review in accordance with the family’s wishes.
• The Resource Allocation guides the planning process.
• Through improved information, the plans are more aligned with the needs of the individual.
• Utilization Management reviews the plan with a specific focus on waiver compliance, health and welfare and to assist individuals who have unique needs and need customized budgets to receive needed services.
• This refocus provides increased efficiency and consistency to the ISP review process.
• Stakeholders experience a more streamlined ISP approval process.
• Clinical efficacy of services are evaluated through Utilization Review.
Touch Points of Resource Allocation and the Planning Process

Information shared during planning
Category /Budget are provided to the individual/family

Plan Development
The individual/planning team discuss whether the budget will meet the individual’s needs and access “safety nets” if additional funding is needed.
Touch Points of Resource Allocation and the Planning Process

Plan Development
The person makes the final decision about the services and supports that are requested regardless of the budget.

Plan Submission
The plan is reviewed. If services are requested beyond the budget, temporary, permanent, and intensive review options are explored as the plan is reviewed. All services requested are reviewed to determine if they are medically necessary.

Copyright © 2015 Cardinal Innovations Healthcare Solutions. All rights reserved.
Plan Approval
If the services requested meet the needs of the individual the plan will be approved.
If the services do not meet the person’s needs, or are in excess of the person’s needs, they will be denied and offered appeal rights. Other services may be recommended.

Plan Updates
The individual and their team are constantly in contact concerning changing needs. When new needs are identified and necessary, budget changes are made.
• The individual requests services in the type, frequency and intensity they desire
• The individual budget is used as a guideline in planning
The Resource Allocation model contains “safety nets” to ensure that every individual has access to the services that they need.

- Temporary Change
- Permanent Change
- Transition from child to adult (turn 22)
  - Non-Residential to Residential (and vice versa)
  - New SIS® - new category assignment
- Intensive Review
- If services are medically necessary they will be approved. CMS requires that services meet criteria for medical necessity.
Temporary Changes in Need

• Temporary changes allow the individual to access additional funding and remain in their current category. This increase is provided for issues that are expected to last six months or less that are unplanned and unexpected.

• The planning process emphasizes preparing within the plan for any situations that might require a service increase in the upcoming year that are known, (for example vacations, upcoming surgeries) within what is reasonable.
Permanent Change in Need

• Permanent changes allow the individual to access additional funding when a change in category or matrix is indicated. **This increase is provided for issues that are expected to last longer than six months.**
  
  – Examples of reassignment to a new matrix or category based on:
    
    • a change in living arrangement (Private Home to Residential and vice versa)
    • a change from child to adult (individual turns 22)
    • a change in clinical support needs as identified by a new/addended SIS®
**Strategy for the development of an intensive review category:** To ensure a fluid/flexible process to increase budgets as life changes for individuals/families when unique situations occur that do not meet the criteria for temporary or permanent changes or individuals have needs that cannot otherwise be met within their category budget. The budgets in the Intensive Review category are set for each person up to the $135,000.00 waiver cost limit.

Intensive Review is a category for individuals who may have a need for additional supports beyond their category assignment and/or base budget amount. Examples of types of requests: if someone has needs that they feel cannot be met they can request Intensive Review.

Examples:
- Post-secondary Education
- Exceptional Medical
- Exceptional Behavioral
- School-aged individuals who graduate from/complete high school prior to age 22
Intensive Review Process

Request Prior to the planning meeting:

• Individuals have the option to have a team of cross disciplinary/cross departmental staff review the request before the plan is submitted to Utilization Management for review and provide a recommendation for placement in the Intensive Review Category. This option allows for back and forth discussion about the issue inclusive of an observation of the person and the opportunity to request additional clinical information and/or assessments.

Request with the plan:

• Individuals have the option to add their request for Intensive Review to their Individual Support plan and make the request to Utilization Management.

Assigned to the category during the Plan Approval Process:

• Individuals do not have to formally request Intensive Review in order to have services authorized in excess of their base budget, if such services are determined to be medically necessary.
Intensive Review is not generally intended to be a permanent placement and the planning team supports the individual/family in exploring all of the clinical and funding options available as they determine whether Intensive Review should be requested, and, if placed in Intensive Review, to work toward movement back to the appropriate category, if clinically indicated.
Building on What is Working
What did not work:

• Mid authorization changes in budgets.
• Did not implement the Resource Allocation (Individual Budget) with enough emphasis on the Planning Process.
• We did not prepare individuals/families with information on their past utilization of service to assist in understanding how that aligned with their budgets.
• We initially used outside contracted psychologists to complete the SIS® and found that our scores were inflated, and high levels of inconsistency among SIS® evaluators.
• Began with a divided stakeholder group, one for providers and one for family members.
Lessons from the Pilot

What did work:

• The design was correct and effective.
• A stakeholder group that was integrated with individuals/families and providers to inform the design, implementation and ongoing operation.
• A planning process that is guided/informed by an Individual Budget.
• The shift in focus for Utilization Management to authorize/ manage services and supports in line with the values of the ID/DD service system and focus resources on individuals to ensure they are receiving what they need.
What did work:

• Fiscal stability and predictability, with full implementation of the current design.

• Assessment system that informs Person Centered Planning (ISP) which includes the SIS®.

• A system that promotes flexibility and choice for the individual/family to choose an appropriate array of services, rather than an MCO prescribing one array of services.

• The model adapts to the changing circumstances of day to day life for individuals/families and the business needs of providers.
Questions?
Andrea Misenheimer
Director of Regulatory Affairs
Cardinal Innovations Healthcare Solutions
andrea.misenheimer@cardinalinnovations.org