



West Virginia Developmental Disabilities Council

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WV Developmental Disabilities Council Comments on Proposed Changes to the IDD Waiver May 2018

The Council appreciates the opportunity to submit comments on the Bureau for Medical Services' proposed changes to the IDD Waiver following the recent forums held throughout the State. Council staff attended most of those forums, listening to service providers and family members as they learned about the proposed changes. After careful reflection, the Council offers the following for consideration.

Independent Service Coordination: It is now unclear what the Bureau intends to do about independent service coordination, since the information in the Power Point presentation no longer matches that presented at the forums attended by Council staff.

The Council recommends that any change to independent service coordination should happen on a certain date, rather than across the span of a year, for several reasons.

To comply on July 1, 2020 under the anchor date model, implementation would need to begin on July 1, 2019 to ensure everyone would be transferred in time.

If a set date is not used, new service coordination agencies would most likely struggle to stay in business due to receiving new customers on an irregular basis, and current provider agencies would be required to maintain a service coordination component and staff with a regularly shrinking clientele.

The Council believes the State should be setting policy and announcing plans now for service coordination agencies to be developed, certified, and ready to begin business by July 1, 2020. This will be critical in order to make determinations of which agencies and in what areas of the state it may be necessary

for an agency to continue to provide both service coordination and other IDDW services. The terminology “no other willing and qualified agencies within a close geographical distance” is too vague to make determinations. If there are no other willing and qualified agencies within some geographical area, how will it then be possible that a person will receive service coordination from one and IDDW services from another?

Whatever method is used, providers, families, and people using Waiver services need to be kept up-to-date on plans for implementation. Few families or people using services attended the forums. They need to be made aware of this change. They will need information provided to them directly from the State on how this will work, what choices will be available in their area, and how and when to make the change.

Behavior Support Professional (BSP) Service Limits: The Council understands the Bureau’s desire to curtail spending on services they find to be non-beneficial to people using them. However, the “empirical data” and assumptions used to make this determination is flawed and may not reflect the true benefit of the service. For instance, Individual Program Plans (IPPs) were not reviewed to determine if positive behavior support plans were included, and a further look to see if a particular behavior may have been addressed but a new one now needed attention was not done. Studies have shown that “behaviors” often have a medical cause (often due to unrecognized dental problems), in which case the best behavior support plan will not solve the problem. A superficial look at ICAP scores and billing do not constitute a thorough review of the issue.

Apparently, another major factor in determining this service has not been beneficial was information discovered during reviews conducted by the Utilization Management Contractor in which incomplete behavior support plans or those that had been copied and pasted (and therefore not individualized) were found. The Council understands that when incorrect billing is found during these reviews, agencies are only required to pay back funding for the instances found during the review. **Is there no mechanism within the Bureau to pull all the billing associated with a particular problem and require pay back for all incorrect billing?**

The Council suggests the Bureau take steps to hold agencies responsible for developing behavior support plans correctly, make certain the training received and

the evaluation tool used during surveys are compatible, and be more aggressive in recovering payment that is not in compliance with funding requirements. After these steps are in place the current BSP limits could be reviewed again if it is still necessary.

At this time, the Council strongly disagrees with making a cut to the service, which is more than 66% in family settings and 54% in ISS/group homes. This service is critical for the growth and well-being of many people and would be far more so if it was properly carried out by qualified personnel. Improve the quality of service. Do not cut it.

The Council is neutral on the plan to merge BSP I and BSP II into one service code and establish a new rate.

The Council strongly agrees with strengthening policy related to BSP services. This may be all that is needed to ensure the proper use and billing for these services.

Participant-Directed Goods and Services (PDGS): The explanation given at the forums for restricting or eliminating this service was that many of the items requested could be purchased through the Environmental Accessibility Adaptations (EAA) service and that other approvable requests generally fell into one of the four categories being suggested (music therapy, vision, dental, and gym memberships).

PDGS has been defined in the current Waiver application as “services, equipment, or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP” and also meet several requirements, including “an item or service that would decrease the need for other Medicaid services and/or promote full membership in the community and/or increase safety in the home environment and local public community and/or assist the individual is (sic) self-directing his or her services.” Although the Bureau has gone on to make several such things non-permissible, there are items other than the four proposed that meet that criteria.

PDGS was included as a service in the participant directed option at the suggestion of the work-group that provided input into the development of the option to allow people who self-direct to have a little more control over their services. That group did not foresee the restrictions that would be placed on the

service by the Bureau during implementation. In fact, several of those restrictions were specifically discussed as examples of items that could be purchased to help people be more independent and included in their communities. For example, with a microwave oven someone might cook their own meals. With a cell phone or computer, they could stay in touch with friends and family. With a communication device, they could communicate with others! These are all items that meet the criteria for need established. Gym memberships contribute to overall health and well-being, can increase community inclusion, and can possibly decrease “behaviors.” They should not require medical documentation to be purchased.

Since the financial cap on PDGS was combined with EAA services, there does not appear to be any financial advantage to the Bureau in eliminating the service.

We understand some people have expressed dissatisfaction that the service is available to those who choose to direct their own services but not to those who use traditional services. If this is the reason for possible elimination of the service, the Council suggests the service be available to all. The \$1000 cap on PDGS and EAA combined would not cost the program significantly more money if it were open to everyone.

The Council strongly disagrees with either the elimination or the limitations proposed to participant-directed goods and services.

Personal Options Readiness Assessment: The Council believes the Fiscal Management Services (FMS) entity already explains to those who choose to self-direct their services what is required to do so and provides orientation and training to assist the person in acting as an employer.

Since the Readiness Assessment tool cannot be used to deny a person the opportunity to direct their own services, and since the Bureau already has the ability to require a person to transition back to traditional services if they are unable or unwilling to maintain compliance, the Council does not believe the new tool is necessary.

Other possible changes to the Waiver were not solicited but the Council would like to offer a few.

Approved Medication Assistive Personnel (AMAP) services: In recognition of the additional training and responsibility of staff who function as AMAPs, the Council supports an increased differential in the rate of pay from that of other direct support services staff.

Pre-Vocational Agency Staff and Supported Employment Agency Staff: Likewise, in recognition of the knowledge and responsibility required to perform these functions properly, the Council supports an increased differential in the rate of pay from that of other direct support services staff.

Pre-Vocational Service Location: The “site of service” needs to include “community settings” (as was stated in the BMS Provider Manual Chapter 513 of 12/1/2015). Learning and demonstrating the competencies learned in a variety of community work settings would optimize the attainment of the outcomes identified in the service description for 513.15.2 Pre-Vocational. Limiting this service to a “licensed IDD Facility-Based Day Program Facility” will not enhance, and in fact will create barriers to, the desired adaptive competency learning for people, particularly those who have intellectual disabilities.

We hope these comments will be helpful as you begin to develop the 2020 Waiver application and look forward to reading it, at which time we will offer further comment.