Pre-Implementation Review Findings

July 2021

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Prepared for

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Contents

Background

Since 2016, Human Services Research Institute (HSRI) has been under contract with the Idaho Office of the Attorney General to assist the Idaho Department of Health and Welfare (DHW) in designing and implementing a new personal supports budget methodology, or resource allocation model, for assigning budgets to adults with intellectual and developmental disabilities (IDD) receiving Medicaid Home and Community Based Services (HCBS). This effort will result in support levels being assigned to service recipients based on their general support needs and extraordinary support needs. Subsequently, each support level will be associated with a service mix and supports budget that is commensurate with the amount of support needed typical of the individuals in the level.

Much of the work associated with designing the new resource allocation model has been completed to date, including: developing a leveling framework and level assignment criteria, establishing the applicable service array, and developing a series of service mixes to establish the support budget available to participants with varying support needs. Pre-Implementation Review (PIR) is a key step in finalizing the framework and determining what service mixes and associated budgets DHW will seek to offer under the new framework.

In this report, we will reiterate key elements of the model that were reviewed as part of PIR, explain the methodology associated with this qualitative review process, detail

the findings from PIR, and provide a series of recommendations for DHW to consider as they prepare for implementation.

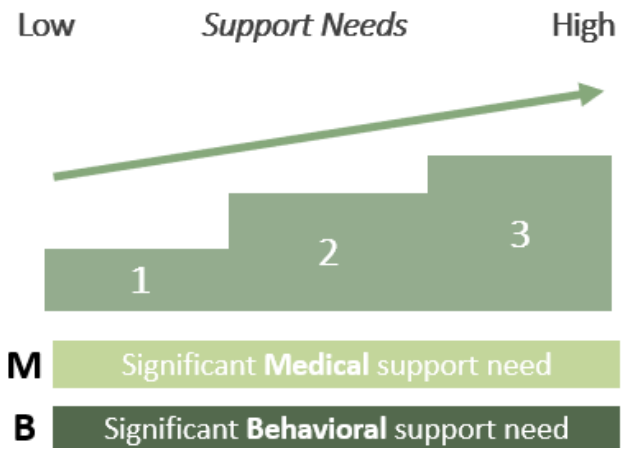
Elements of the New Resource Allocation Model

The goal of PIR is to determine whether the draft support levels and service mixes will meet most people's needs when implemented.[1] The review is an examination of the five-level framework, support level descriptions, and the service mixes and budgets to ensure all are operating as intended. In this section we provide a brief summary of those elements of the new resource allocation model that were reviewed during the PIR process. Additional detail about each of these elements will be available in the forthcoming *Development* of *Idaho's 5-Level Resource Allocation Model - Final Report*.

5-support level framework

The graphic in Figure 1 illustrates the 5-level framework HSRI proposed for use in Idaho. Levels 1, 2, and 3 include individuals with low, moderate, and high general support needs, respectively. Level M is assigned to individuals with exceptional medical support needs, while Level B is assigned to individuals with exceptional behavioral support needs. Individuals assigned to Level M or Level B may have general support needs that would have placed them into Levels 1, 2, or 3; however, their level assignment is based on their extraordinary medical or behavioral support need. Individuals are assigned to only one level. The same standardized criteria determine a participant's placement into Levels 1, 2, 3, M, or B irrespective of his or her choice regarding how to receive services (traditional approach or self-directed approach) or chosen type of residential habilitation supports.

Figure 1. 5-Level Framework



[1] For a brief overview of the purpose of PIR and steps involved see *Pre-Implementation Review Purpose and Process* (March 16, 2021) at mychoicematters.idaho.gov.

HSRI has conducted a variety of analyses to determine the best way to group individuals with like support needs and has developed and modified support level frameworks over the years based on the results of this ongoing analysis. For information regarding the analysis completed to develop the 5-level framework using the SIS-A please see the memorandum titled, *Moving from Seven to Five Support Levels for Determining Personal Supports Budgets*[2].

PIR seeks to explore whether needs increase from levels 1-3, that individuals assigned to M or B have extraordinary support needs, and that individuals in the same level have similar support needs.

One overarching purpose of PIR is to explore the 5-level framework, including whether adults in the same support level have similar needs, that needs increase with support level, and that Levels M and B contain individuals who require extraordinary support.

Level descriptions

HSRI develops and provides level descriptions as a means to provide greater clarity as to the typical characteristics of participants at each support level. HSRI developed and shared draft level descriptions, shown below in Figure 2, for Idaho's 5-level framework in July 2020. These draft descriptions are based on level descriptions developed in other jurisdictions where HSRI has worked to establish similar support level frameworks.

Figure 2. Preliminary Level Descriptions

Preliminary Level Descriptions	
1	Adults in this level have low support needs, with little to no support necessary for focused medical or behavioral challenges. They can manage many aspects of their lives independently, or with little assistance. Someone in this level may need supports with clothing care, preparing meals, and dressing. Often, the support needed involves some monitoring or prompting instead of partial-to-full physical support. They may need intermittent help participating in leisure activities, gaining and maintaining employment, visiting family and friends, or assistance with shopping. They usually can ambulate or need minimal help moving about with the proper equipment, but need help with health practices, such as maintaining a nutritious diet and being reminded to take medications as prescribed.
2	Adults in this level have modest or moderate support needs and little to no support necessary for focused medical or behavioral challenges. They require more support than those in Level 1 but may have minimal needs in some life areas. An individual in this level may need some assistance preparing and eating meals. They might need monitoring or prompting with daily dressing, and daily assistance with housekeeping and laundry. They may need support getting from place to place, gaining and maintaining

[2] Can be found at mychoicematters.idaho.gov as Framework Development Analysis

	employment, accessing public services or interacting with community members. In this level, they most likely will need partial physical assistance taking medications, avoiding health and safety concerns and maintaining a healthy diet.
3	Adults in this level have moderately high to very high support needs and may need significant, but not extraordinary, medical support. They often need some physical assistance with life activities on a daily basis, including oversight throughout the day with 1:1 support for some portions of the day. They may have behavioral support needs which require increased monitoring or intervention, but which do not rise to the level of extraordinary. In this level, an individual will likely need daily, and often physical, assistance preparing food, eating meals, dressing, bathing, and completing other household activities. An individual in this level will likely also require partial-to-full physical assistance in order to gain and maintain employment, access the community, visit friends and family members, or participate in preferred community activities. They will most likely need at least partial physical assistance obtaining health care.
M	Adults in this level have a significant need for medical support, regardless of their support need to complete general daily activities. They may also need some support due to behavior, but this support is not extraordinary. In this level, an individual has a chronic or acute medical condition that is so complex or unstable that one-to-one staffing is required to provide frequent interventions and frequent monitoring. Without this level of intervention and monitoring the individual would require placement in a nursing facility, hospital, or ICF/ID with on-site nursing.
B	Adults in this level have significant behavioral challenges, regardless of their support need to complete general daily activities or for medical conditions. In this level, an individual requires intense 24-hour support and supervision due to one of the following: a recent felony conviction or charges for offenses related to the serious injury or harm of another person, a documented history of predatory sexual offenses with a high risk to re-offend whether or not they have been involved with the criminal justice system, a documented or sustained history of serious, aggressive behavior which requires continuous monitoring to prevent potential injury to themselves or others.

As part of the final step of PIR, reviewers are asked to provide feedback to allow these descriptions to be refined and expanded upon to best reflect the support needs of individuals in each of Idaho's five support levels. This feedback will allow for improvements to the accuracy and understandability of the descriptions to make them as useful as possible in implementation.

Service mixes and budgets

Budgets within the new model are created using service mixes. A service mix identifies the average type and amount of services Medicaid anticipates people will use within each support level. Some services focused on health and safety and employment are not included in the service mixes. These services will be made available outside of the adult's assigned budget so that someone who wants and needs these services can receive them without having to forego desired discretionary supports. Participants are not required to use the specific services that are included in their service mix. The service mix developed is the model used to calculate the available budget which an individual can then use to purchase the combination of services that best meet his or unique needs.

Four basic service mixes were developed based on the type of residential habilitation supports the adult chooses to receive. Each service mix is further divided by support level (1, 2, 3, M, and B). As proposed, adults who self-direct will receive budgets based on the same service mixes developed for adults who choose the traditional approach for receiving services. DHW is currently developing criteria to determine which traditional residential habilitation support option most resembles the way an adult is using their self-directed supports. This will determine which traditional service mix best corresponds to the applicable service mix for adults who self-direct. It is important to note that while the services that make up the service mix are identical, self-directed final budgets will be slightly different than traditional budgets to account for unique costs associated with self-direction and different overhead costs applicable for Supported Living Services (SLS) in traditional versus on self-direction.

PIR seeks to confirm that support level descriptions reflect the needs of adults in each support level and adjust the descriptions as needed.

In total, seven unique service mixes with corresponding budgets were developed. Figure 3 provides the name of each of these service mixes at the time of PIR and the shortened label for each mix you will find within the *Findings* section of this report.

Figure 3. Proposed Service Mixes

Title of Service Mix	Abbreviated Label
Certified Family Home Service Mix	CFH
Supported Living Service Mix	SLS
No Paid Residential Habilitation Supports Service Mix	Non-Residential
State Plan HCBS Only*	State Plan HCBS Only
Self-Directed community support services similar to Certified Family Home	SD (like CFH)
Self-Directed community support services similar to Supported Living	SD (like SLS)
Self-Directed with No Residential Habilitation Community Support Services mix*	SD (like NonRes)

* Service Mix not reviewed as part of PIR

In February 2021, HSRI facilitated a 3-day process where DHW developed an initial proposal for how many hours of each available discretionary service they would include in each service mix for each support level. This was completed by considering how much of each service they thought adults at each level would want and need as informed by their assessed support need, typical historical use patterns, and DHW's own policy intentions. These initial draft service mixes were shared with self-advocates, families, providers, and other stakeholders. For the full packet of materials shared with stakeholders regarding the initial draft mixes please see *Understanding Service Mixes*[3] .

Stakeholders were encouraged to ask questions and provide input and recommendations for possible changes to these initial draft service mixes. DHW received and reviewed more than 125 written comments regarding the draft service mixes. Based on this feedback, DHW made a series of changes to the draft service mixes. For a full account of the information which led to these service mix adjustments see *Revised and Updated Service Mixes*[4].

Figure 4 displays one of the revised service mixes reviewed as part of PIR. For the full list of service mixes at the time of PIR see the Appendix.

[3] Can be found at mychoicematters.idaho.gov as Service Mix Packet (February 19, 2021).
[4] Can be found at mychoicematters.idaho.gov as Revised Service Mixes Utilized for PIR (April 5, 2021).

Figure 4. PIR reviewed Certified Family Home (CFH) service mix

Certified Family Home Service Mix					
Supports Level	1	2	3	M	B
Residential Supports: CFH	365 days	365 days	365 days	365 days	365 days
Adult Day Health	4	4	5	0	0
Developmental Therapy/Center	5	5	5	0	0
Developmental Therapy/Community	5	5	5	0	0
Prevocational Individual	0	0	1	2	2
Prevocational Group	0	0	1	0	0
Career Planning	1	1	1	2	2
Community Habilitation Individual	3	4	6	17	17
Community Habilitation Group	5	7	5	0	0
Total Hours Per Week:	23	26	29	21	21
Non-medical Transportation	3600 miles	3600 miles	3600 miles	3600 miles	3600 miles
Service Coordination/Planning	$3,192	$3,192	$3,192	$3,192	$3,192
Total Budget Range Per Year:	$39,453 to $43,287	$41,851 to $46,295	$44,339 to $52,407	$46,517 to $65,587	$46,517 to $65,587

As shown above, service mixes vary by support level. Each column displays a different support level while individual services included in the mix are displayed in each row. The first row reflects the residential supports included in this service mix. Certified Family Home providers are expected to provide appropriate and adequate supervision for 24-hours each day according to the participant's plan of service a day and are paid a standard daily rate. For this reason, the amount of support built in the mix for each level accounts for 365 days of support. For rows labeled Adult Day Health through Community Habilitation Group, the number displayed in the corresponding cells are

the number of hours per week of that service included in the mix. Non-medical transportation is displayed as the number of miles included in the service mix and is consistent across support levels. For service coordination and planning $3,192 dollars is included at each level. This amount is also consistent across service mixes and amounts to 4.5 hours a month of service coordination and 12 hours per year of plan development support. The final row displays the total budget range per year for each mix. This number is displayed as a range because the service rates applicable for all services within the mix have not yet been finalized. During PIR, the low end of the range was used to determine whether even the lowest anticipated budgets would be adequate for most participants. Once the Idaho legislature has approved the rates for all applicable services these will be adjusted to reflect the total available budget.

PIR seeks to explore whether service mixes and budgets are generally adequate in each support level. If any service mix or budget is not adequate, PIR seeks to explore why and how it may be improved.

PIR seeks to explore the service mixes and budgets to identify whether they are generally adequate in each support level, and if not why. This inquiry includes looking at the individual services that comprise the mix to determine whether they reflect a combination of services that are generally needed and desired by participants and looking at the overall budgets to see if they will meet needs by service mix and level. In those instances when it appears the service mix and budget may not meet individuals' need PIR seeks to identify and understand the reasons why not.

Purpose of Pre-Implementation Review

The Background section of this report offers a brief overview of the development of the new resource allocation model and describes how PIR will be used to review the model itself. To summarize, the purpose of PIR is to explore three key elements of the resource allocation model to ensure they meet most people's needs. The table below summarizes the model elements PIR explores and the associated research questions.

Figure 5. Resource allocation model elements and associated PIR research questions

MODEL ELEMENT	PIR RESEARCH QUESTION
5-support level framework	Do general support needs increase from Levels 1 through 3?
	Do adults assigned to Levels M and B (and only adults assigned to Levels M and B) have extraordinary need for medical support or behavioral support, respectively?
	Do adults in the same support level have similar support needs?
Support level descriptions	Do descriptions reflect the support needs of individuals in each of the 5 support levels? How can descriptions be improved for accuracy or understandability?
Service mixes and budgets	Are service mixes and budgets generally adequate in each support level?
	If any service mix or budget is not generally adequate, why?
	What, if any, adjustments to the service mixes or budgets may be made that will better reflect potential service need?

Methodology

Approach

The PIR process was adapted specifically to review the new resource allocation model being developed for the Idaho Adult DD Program. The methodology of PIR draws extensively from data collection processes conducted by HSRI in multiple other jurisdictions.[5] PIR uses a qualitative approach to collecting information and analyzing findings towards the purposes detailed in the Background section. This approach, unlike quantitative-only approaches, is best suited for the specific goals of PIR. This section describes why we have developed and refined our qualitative approach for PIR.

First, qualitative research aims to provide an in-depth, detailed, and information rich understanding of a topic.[6] This is in contrast to quantitative methods which have been used in other aspects of the resource allocation model development. We apply qualitative methods here to allow for a deeper understanding of why support levels seem to work in accordance with the model described in the Background section and whether/why service mixes and budgets are adequate. Moreover, by using a

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[5] For example, see information about record review for the Minnesota Waiver Reimagine project https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/waiver-reimagine/reports/.

[6] Snape, D. & Spencer, L. (2007). The Foundations of Qualitative Research. In J. Ritchie & J. Lewis (Eds.) *Qualitative Research Practice* (5th ed., pp. 1 – 23). Sage Publications.

qualitative approach, we will gain a better sense of where and how improvements may be made to elements of the resource allocation model.

Qualitative research intentionally limits the sample size to allow for in-depth exploration. For the purposes of PIR, we include the records of 100 current program participants who were part of the SIS-A first cohort. This is contrasted with quantitative methods which often require a large number of individuals to reach a level of statistical power that is deemed sufficient to draw conclusions. Instead of statistical power, qualitative research seeks to reach data saturation whereby enough interviews/focus groups/document reviews are conducted so that little or no new information is added to the findings. This data saturation is commonly reached with a sample size of 6 to 12 for each group in the study[7]. For the purposes of PIR, the sample size was estimated based on the number of service mixes and support levels as well as past experiences reaching data saturation conducting similar data collection activities.

Qualitative analysis provides detailed description as well as classification or quantification of some aspects of the findings for ease of interpretation. Though a sample of 100 participants may seem relatively small, the amount of documentation reviewed for those participants was extensive, equaling thousands of pages of information reviewed in order to detail their support and service needs. To successfully analyze the information gathered about the sample, we applied data reduction techniques in the production of data collection materials (e.g., questions on a form to ask of each record) as well as the presentation of findings (e.g., tables and graphs in the Findings section of this report). The techniques we apply for PIR, which align with similar approaches to data reduction for qualitative analysis[8], have been refined through our experience conducting similar data collection activities in other jurisdictions.

Lastly, applying a qualitative approach lends to the triangulation of various analyses and activities completed in development of Idaho's new resource allocation model. All steps of the development have included to some degree quantitative analysis of support needs, service use, and potential budget amounts. By integrating a qualitative approach to PIR, we are able to integrate mixed methods into our overall approach and better triangulate the overall goal of creating a support level framework, level descriptions, service mixes, and budgets that will work for most people. Such triangulation enhances previous quantitative phases of the work and provides additional support for the findings (i.e., resource allocation model)[9].

As with any approach and methodology, the method developed for PIR has limitations. Perhaps most notably is that findings from PIR lack statistical

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[7] https://researchforevidence.fhi360.org/riddle-me-this-how-many-interviews-or-focus-groups-are-enough

[8] Spencer, L., Richie, J., and O'Connor, W. (2007). Analysis: Practices, Principles, and Processes. In J. Ritchie & J. Lewis (Eds.) *Qualitative Research Practice* (5th ed., pp. 199 – 218). Sage Publications.

[9] Barbour, R. S. (1999). The Case for Combining Qualitative and Quantitative Approaches in Health Services Research. *Journal of Health Services Research & Policy*, *4*(1), 39–43.

probabilistic generalizability. That is, this report contains numbers and percentages of individuals for various findings (e.g., the percentage of individuals who were deemed outliers in the sample) that cannot be directly applied to the population of adults served on the DD waiver due to the sample size and lack of inferential statistics applied to findings. Instead, qualitative research seeks to identify themes and key elements in the context of a specific inquiry using a variety of analytic techniques to summarize findings in ways that can be informative about the larger population[10]. For PIR, this means that we generate overarching themes about the support needs and service mixes that will apply to individuals in the DD program, then present specific findings with frequencies or percentages of the sample to provide more detail and context to promote understandability. While specific numbers and percentages should not be generalized to the overall population, the themes presented in the findings should be considered generalizable to some unknown proportion of the population. That is, a finding that a specific percent of the sample is found to be outliers is notable only in that outliers exist in some relatively small proportion of the population. The more important and useful information to be drawn from the finding includes the reasons outliers seem to exist.

Sample

Figure 6 displays the number of participants whose records were reviewed as part of PIR. The figure displays the 100 individuals by assigned support level and applicable service mix. Note that while the service mixes used to establish budgets for self-directed services mirror the corresponding traditional mixes, the budgets differ slightly and are therefore treated as separate service mixes.

Figure 6. PIR Sample by Support Level and Service Mix

	1	2	3	B	M	Total
CFH	4	5	3		3	15
SLS	11	8	8	20	6	53
Non-Residential	6	2	2		2	12
SD (like CFH)		7	6			13
SD (like SLS)		2	4	1		7
Total	21	24	23	21	11	100

The sample was drawn from those participants with SIS-A assessments (hereafter referred to as the first cohort). Sample participants were randomly selected from each service mix and support level combination as possible (i.e., there were individuals in that service mix and support level to draw from). HSRI sought to include a similar number of adults from each level as part of the PIR sample, identifying that including 20 participants from each level would likely exceed the number needed to achieve data saturation. However, only 13 individuals from cohort 1 were assigned to Level M

[10] Ayres, L., Kavanaugh, K., and Knafl, K.A. (2003). Within-Case and Across-Case Approaches to Qualitative Data Analysis. *Qualitative Health Research*, 13(6), 871-883.

making this the maximum number of participants who could be included in the sample for that level.

Many of the questions being addressed through PIR relate to the ampleness and applicability of the service mixes being offered. Individuals who are no longer receiving Adult DD services were removed from the sample as they would not be transitioning to the new budget model. Where possible these participants were replaced with an adult who most resembled them in assigned support level and applicable service mix. Participants assigned to Level M who were no longer receiving services had to be replaced with someone in a different level as every adult in Level M was already included in the initial sample. Two participants assigned to Level M were no longer receiving services at the time of PIR, thereby bringing the total number of participants reviewed within Level M to 11.

Sample considerations

HSRI determined that a sample size of 100 would be more than adequate for the planned analyses. A qualitative approach requires that a sample is sufficiently large to reach data saturation rather than statistical power. Data saturation is the point in which the findings from the research become redundant, that is, no new information is discovered about the phenomena of interest. In PIR, data saturation is reached when individuals from a specific support level seem to have support needs within the same range and services mixes seem adequate (or inadequate) for most in the level except for identifiable outliers with defined reasons for their outlier status. The qualitative literature often cites that a sample of about 6 to 12 per analysis group is sufficient to reach data saturation in interviews[11], which is transferable to the information collected with a record review like PIR.

Three limitations to the sample are noted. First, the sample pool was limited to the 800 members of the first cohort. To answer the research questions regarding the 5-level framework, it is necessary to review information about participants assigned to each support level (1, 2, 3, B, M). Therefore, only those participants with completed SIS-A assessments could be included.

Second, two service mixes could not be included in the PIR. Service mixes for purposes of pulling the sample for PIR were determined using state fiscal year 2019 expenditures data. That data source did not make it possible to differentiate between participants who would receive the State Plan HCBS Only mix and those who would receive the No Paid Residential Habilitation Supports Service Mix. Furthermore, at the time the sample for the first cohort was initially pulled no participants using State Plan HCBS Only services were included, thereby reducing the likelihood any such

[11] https://researchforevidence.fhi360.org/riddle-me-this-how-many-interviews-or-focus-groups-are-enough

individuals would be included in the PIR sample[12] [13]. State fiscal year 2019 expenditures also did not allow for differentiation between the three self-directed service mixes (SD (like CFH); SD (like SLS); SD (like NonRes)) as this differentiation is not part of the existing system. All participants who were identified as receiving self-directed services using (SFY 2019 expenditures) were included in the PIR sample, however, none of those individuals were identified as meeting the criteria to receive the Self-Directed with no residential habilitation community support services mix. Therefore, the State Plan HCBS Only and the Self-Directed with no residential habilitation community support services mix were not included in the PIR. HSRI attempted to include maximal representation of adults in each service mix, as one of the aims of PIR is to explore the adequacy of services mixes and budgets.

Third, it was not possible to include representation for all support levels in all included service mixes. Adults in Cohort 1 assigned to Level B almost exclusively utilize supported living services and would therefore be assigned to that service mix. To ensure adequate representation of participants in Level B, 20 participants assigned to that level were included from the SLS service mix, thereby requiring more overall participants from that mix to be included in PIR than were included for other mixes. None of the adults in Cohort 1 who self-direct their services were assigned to Level 1 or Level M. Therefore, no one from those levels were included in the PIR for those service mixes.

Procedure

Pre-Implementation Review occurred over a 5-day period from March 22nd through March 26th. The process was conducted by seven members of the Bureau of Developmental Disabilities' quality assurance staff and four members of the independent assessment provider's staff, hereafter referred to as reviewers. HSRI facilitated the review process which included preparing all materials, conducting all training, and facilitating each of the three small groups which completed the review. While this review process and materials were specifically developed for use in Idaho, the overarching approach and methodology has been used in numerous other jurisdictions where HSRI has been involved in the development of new budget models.

In this section, we will detail the training reviewers received, the materials that were used and referenced during the PIR, and the process for conducting the review. The figure below displays the calendar of PIR activities that are described in more detail next.

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[12] For more information regarding the process for determining who would receive a SIS-A as part of Cohort 1 see *Understanding Service Use and Costs Among Service Recipients in Idaho's Adult Developmental Disabilities Program—Part 4 of 4: Service Utilization, Expenditures, and Location Relative to Providers of Cohort 1.*

[13] Due to the ability for waiver eligibility to change over time limitation of the first cohort to participants on the Adult DD waiver does not preclude the possibility that some first cohort members are no longer on the Adult DD waiver while still receiving services from the Adult DD program under the State plan.

Figure 7. PIR activities calendar

ACTIVITY	DATE	TIME
Watch PIR introduction	by 3/22/21	anytime
Part 1 live training	3/22/21	9:00am – 11:30am
Part 1 partner reviews	3/22/21	11:30am- 5:00pm
Review records independently	3/23/21	Before 1:00pm
Part 1 Small Group Reviews- Day 2	3/23/21	1:00pm – 5:00pm
Review records independently	3/24/21	Before 1:00pm
Part 1 Small Group Reviews- Day 3	3/24/21	1:00pm – 5:00pm
Review records independently	3/25/21	Before 1:00pm
Part 1 Small Group Reviews- Day 4	3/25/21	1:00pm – 5:00pm
Part 2 live training	3/26/21	9:00am – 10:30am
Part 2 small group meeting	3/26/21	10:30am – 2:30pm

Due to COVID-19, all aspects of PIR were completed remotely. The PIR introduction was a recording on Zoom, and all other training and meeting components were live on Zoom. Reviewers were able to access digital records via their secure networks to independently review records remotely. While HSRI commonly conducts similar data collection activities in other jurisdictions in person, the travel restrictions and safety of all individuals involved would not allow an in-person PIR. However, the remote process allowed for reviewers to have extended time to complete their independent reviews at their own pace, which may be beneficial to the accuracy and completeness of the collected data on each record.

Training

Prior to March 22nd, reviewers were asked to complete a 30-minute pre-training (PIR introduction) which provided a high-level review of the elements of the new resource allocation model and an introduction to the expectations of reviewers as part of PIR. Reviewers were also asked to briefly review and orient themselves to a packet of instructions for Step 1 of PIR and the Step 1 PIR Form.

On Day 1 of PIR, HSRI provided a live training for reviewers which reiterated key elements of the new resource allocation model necessary to conduct the review including: the 5-level framework, an explanation of what a service mix is and how it is used to establish a participant's budget, detail as to what services make up each component of a participant's budget, an introduction to those new services being added to the program's offerings, and details about each of the service mixes being reviewed. HSRI then reviewed the purpose of PIR and the specific steps of the review. Detailed information was included on how to determine which participant records were to be reviewed as part of PIR and how to securely access and save those records

that were reviewed. HSRI provided additional instruction on how to review the specific records reviewers were less familiar with (SIS-A and Critical Incident and Complaints) and how to record any instances where information about the participant's support need differed between the documents being reviewed.

Day 1 training next included instructions for using the Step 1 forms (described in the next section), and definitions of key terms on those forms. HSRI provided an example Step 1 review for an adult currently receiving services in Idaho. The full panel of reviewers completed the group review for that example. The rest of Day 1 of PIR consisted of partner reviews where two or more reviewers independently conducted the first round of review for a single participant. Those reviewers then conferred detailing their analysis process and their draft responses on the Step 1 form. Reviewers came to agreement regarding the responses on that form before presenting the record to the full group, describing their process, and posing any remaining open questions to the group. This process was completed on a total of 10 records, with each reviewer completing two reviews with a partner. Partners varied for each of these review cycles to support greater consistency of responses across the entire panel of reviewers.

An additional training was provided on Day 5 of PIR that provided reviewers with instruction on how to complete Step 2 of the process. This training included a presentation of the Step 2 materials which consisted of a unique packet for each small group and a notes form for reviewers to complete for each level reviewed. Reviewers were given detailed instructions on how to conduct the review for each support level, instructions on how to use the reviewer notes form, and guidance on how to record their feedback on each of the support level descriptions. Training also included reminders on how to securely their Step 2 reviewer form, the only materials individual reviewers produced as part of Step 2.

Materials

HSRI and DHW collaborated on the identification, creation and/or collection of all necessary materials for PIR. The materials necessary for this task include training presentation materials, the *Pre-implementation Review Packet*, Step 1 form, *Pre-implementation Review Step 2 packet*, Step 2 notes form, records for review reference, records of the individuals in the sample, and supplemental materials. These materials are described in this section.

Training presentation materials

As described above, the PIR pre-training video was distributed via email to all reviewers to reference as needed. While all reviewers attended the Part 1 and Part 2 trainings, HSRI also provided the PowerPoint presentation used for the trainings. Copies of training PowerPoints were available to reviewers for reference immediately following the applicable training. See the Training section above for the content of these presentations.

Pre-implementation Review Packet

Reviewers were provided the *Pre-implementation Review Packet* via email ahead of PIR which was the main source of guidance for Step 1 outside of the trainings. It included information such as how to properly title and save participant records and review forms, a list of what participant records were required for review and which additional documents should be sought for review, and instructions on how to search for or access those applicable records. The packet also included detailed instructions on how to complete Form 1 including definitions of key terms (e.g., None, Low, Moderate, High, Extensive with regard to general support need). This packet provided the service mixes being reviewed (available as Appendix A of this report), a list of services available outside of the mix, and those procedure codes reviewer may find listed in ISPs and SSPs to designate approved services. Finally, the packet provided the draft support level descriptions (see page 6 of this report), and the list of records each reviewer was assigned to lead the review for. This list included the reviewer's name and the PIR ID for each participant, a three-digit number developed specifically for the PIR process and which was tied to no other participant records to retain participant confidentiality in the exchange of information during PIR.

Step 1 form

The step 1 form is a data collection tool that was created by HSRI as a document to guide reviewers through the first level of analysis or data reduction. The form asks specific questions about the participant being reviewed, including background information, information on support needs, and information about service needs. HSRI developed this tool to guide reviewers through the qualitative analysis process to ensure that records are coded consistently, and information is tracked thoroughly. Questions in the Step 1 form have been adapted from tools HSRI developed and used in similar data collection activities. Question in the form as well as the definitions and guidance in the *Pre-implementation Review Packet* have been reviewed and used by stakeholders in multiple jurisdictions, including state staff, assessors, service recipients, family members, and advocates. HSRI receives and incorporates feedback to improve the clarity and accuracy of items over time.

Step 1 form questions include a combination of multiple choice, Likert scale, and open-ended items. The variety of question types is intended to provide information that is both readily analyzable across records (e.g., Likert scale items on amount of support needed for ADLs) as well as more expansive and detailed (e.g., description of the supports needed for daily tasks). Shorthand responses to form items were entered into a dataset by HSRI staff during the small group reviews. Reviewers were asked to provide extensive notes for all responses in addition to open-ended items. The original form responses were also collected by HSRI and checked with the dataset for consistency and retained for any necessary use (e.g., finding details of open-ended responses to better understand a particular circumstance). The content of the step 1 form is explained in more detail in the Process section of this report.

Pre-implementation Review Step 2 Packet

On Day 5 of PIR, reviewers were given the *Pre-implementation Review Step 2 Packet,* which consisted of guidance on how to complete Step 2 of the review, draft support level descriptions, and the support need summaries reviewers drafted as part of Step 1 for each participant whose record was being reviewed, organized by support level. Three versions of this packet were provided, one for each small group conducting the reviews. That is, since each small group reviewed a proportion of the overall sample, the version of the packet that group received only contained information on the individuals that group reviewed. All instructions remained consistent between the three versions, with only the support need summaries varying for each group based on the individuals reviewed by the group.

Step 2 notes form

Step 2 was completed collaboratively by each small group, as described in the Process section of this report. To facilitate careful review of the *Pre-implementation Review Step 2 Packet*, reviewers were instructed to fill out the Step 2 notes form for each support level reviewed. The Step 2 notes form was developed by HSRI and adapted from past data collection activities. As with the Step 1 form, the questions have been tailored for use in PIR but draw heavily from past experience and feedback from stakeholders who have been previously involved in similar processes.

The Step 2 notes form is filled out once per support level. The form asks questions about the relative support needs of individuals in the group, including whether any individuals seem to have support needs that are different than most reviewed in their support level. Lastly, it asks for feedback and improvements on the support level description for the level.

Records for review reference

The *Pre-implementation Review Step 2 Packet* contains the specific records each reviewer was responsible for reviewing. However, the list uses PIR IDs to retain the confidentiality of the participants. The records for review reference served as a key for reviewers to identify the individuals to be reviewed in a way that retains confidentiality. The file provides the PIR ID, name, date of birth, and Medicaid ID number for each person included in the review. It was placed on a secure DHW drive and a secure Liberty Healthcare SharePoint site for reviewers to access.

Records of individuals in the sample

The primary source of data for PIR was the actual records of individuals in the sample. DHW maintains numerous records for adults in the program through the information management system developed and managed by the independent assessment provider (IAP). The Liberty Information System (LIS) houses numerous documents for each adult receiving Adult DD services including documents used to establish program eligibility, documentation submitted when seeing approval for Intense Supported Living services, annual assessments for services, notices sent to the participant and/or their guardian, approved plans of service, modifications to plans of

service, and many others. As the specific names of applicable documentation varies by jurisdiction, HSRI sought guidance from DHW regarding which available documents could provide the more complete picture of participants' general, medical, and behavioral support needs. Due to the available timeframe to complete PIR, HSRI sought to establish a semi-standardized list of documents that could provide the necessary information without being overly burdensome for reviewers completing the review. DHW and HSRI established a list of documents, identifying which documents each participant would have available and those documents that would vary by participant.

The following documents were reviewed for every person in the sample: Medical, Social Developmental Assessment (MSDA), SIS-A Assessment, and the current and previous year's Individual Support Plan (Traditional) or Support and Spending Plan (Self-Direction). Reviewers were also asked to search for, and review if available, the following records: Health and Physical, Intense Review Form, Intense Review Supporting Documents, Complaints and Critical Incident Reports made to DHW, Psychiatric Evaluations, Behavioral Management Plans, and Sexual Risk Assessments.

Supplemental materials

Supplemental reference documents were also provided or made available to reviewers as they began PIR to provide additional necessary content and information. These documents included a budget calculator, list of all current or proposed service descriptions,[14] and the proposed Adult DD Fee Schedule[15] built into the PIR budget calculator. The PIR budget calculator was a tool developed by HSRI that allowed small groups to determine how budgets would change if the service mix contained different numbers of hours for specific services. The budget calculator itself was not provided to reviewers. It was operated by the group facilitator during the group review process as needed, with reviewers able to see the calculator shared through Zoom and request different modifications to the calculator for discussion. Reviewers were then able to record notes regarding the fit of the applicable budget as informed by those calculations and ensuing discussion if desired.

Process

PIR began with a full day of training activities as described above. Days 1-4 of PIR were dedicated to completing Step 1 of the review. In total, each reviewer was lead reviewer for 11 reviews. Two of these reviews were completed on Day 1 where two or more reviewers completed the initial review prior to conferring on their responses to the Step 1 Form.

[14] Can be found at mychoicematters.idaho.gov as PIR DRAFT Service Descriptions (March 22, 2021).
[15] Can be found at mychoicematters.idaho.gov as DRAFT Adult DD Fee Schedule Utilized for PIR (March 22, 2021).

Reviewers were given the PIR IDs for those participants for whom they were conducting the initial review and used that number to obtain the necessary identifying information for that participant via the records for review reference. Each reviewer than accessed the Liberty Information System (LIS) to obtain the records for review. Reviewers were expected to take notes during their review to detail information in these records that provided insight into the individual's general, medical, and behavioral support needs. Reviewers were also asked to specifically note those instances where information about the adult's support need appear to conflict between two records and identify, where possible, the cause for this misalignment.

Reviewers then completed the Step 1 Review Form based on the information in the participant's record. They answered background information about the participant such as their age, chosen living setting, and primary diagnoses. They then rated the participant's general support need from none to extensive across five distinct areas. Reviewers were trained on the definitions for each of the ratings and these definitions were available for reference in the *Pre-Implementation Review Packet*. Reviewers were asked to write a narrative, or support needs summary, about the adult which helped to demonstrate their general support needs.

Reviewers then answered questions on the review form regarding the participants medical and behavioral support need. They identified which behavioral concerns or treatments and therapies applied to the participant as indicated in records that were reviewed. They then identified how often the participant required some support and extensive support for behavior and medical needs, respectively. Terms such as "some support" and "extensive support" were defined as part of the training and available for reference while conducting reviews. Using that information as a guide, reviewers were then asked to rate the participant's overall behavioral need and medical needs on a scale of none to extensive, with each term defined specific to the area being reviewed (i.e., behavior supports needs or medical support needs). Reviewers were asked to add to their support needs summary information specific to the participant's behavioral and medical support needs detailing any specifics that help to demonstrate their needs in those areas.

Finally, reviewers were asked to identify which services within the Adult DD service array the participant may want and need based on their specific support needs. They were asked to include an estimate as to the number of hours of that service appeared to be a good fit for the participant. The Step 1 review form provided a checklist of all available services, traditional and self-direction, and provided an open notes field to explain their selections. Reviewers were instructed to consider the individual's support needs, stated goals, and life circumstances to determine possible future service needs and were instructed to not limit responses to those services or amounts of services the participant was currently receiving. Reviewers were asked to consider multiple possibilities for future service use and to provide justifications for their responses. Reviewers had access to the full list of current and proposed service definitions for reference as needed for this part of the review.

Once reviewers had completed their independent review for the day and recorded their Step 1 Review Forms responses, reviewers convened into three small groups of 3 to 4 reviewers, each facilitated by an HSRI staff member. Group members presented information on each adult's support needs using their drafted written responses from the Step 1 form. Using a group discussion process, the group then came to consensus regarding the PIR Review Form responses for each participant. When applicable the lead reviewer then amended their responses on the Step 1 form to reflect final group decisions.

The group facilitator then shared the participant's assigned support level and directed the group to review the applicable service mix for the individual. The group then discussed, service by service, whether the participant needed the service provided in the mix and whether the amount of the service in the mix aligned with the participant's need (does not need, more than enough, meets need, not enough). The service-by-service review was not completed for those adults using self-direction as the services within the mix did not directly translate to the services used within that program.

Small groups were then asked to discuss the mix as a whole—understanding that budgets may be flexibly used to obtain the specific combination of services the individual desired—to determine whether it would be adequate to meet the needs of the individual. Response options for this question included: not at all, somewhat, mostly, and completely.

In those instances where the group identified that an adult would benefit from a combination of services much different than that outlined in the applicable service mix, or where the team identified the adult required more overall services than provided for within the mix, the group then utilized the PIR budget calculator to determine whether the overall mix would be sufficient to meet the adult's needs. The group facilitator would navigate the calculator to the applicable service mix and level and the group would direct the facilitator as to what number of hours per week to enter in the cell for each applicable service. The total cost of the hours entered, based on the rate schedule discussed above, would appear in the total line for the calculator. This calculation was done directly beside cells which outlined the service mix for that level to allow for a side-by-side comparison between the proposed service mix and budget and the services identified by the group for that specific participant.

In those instances where the group identified that the service mix would not meet the needs of the participant the group attempted to quantify the amount of funding and/or type of additional services needed based on their review. Reviewers were finally asked to detail any services outside of the service mix that the participant would benefit from or require. This process was completed for each of the 100 participant's whose records were reviewed as part of PIR.

At the conclusion of each day of PIR, all completed Step 1 forms were collected. The support need narratives from each of these forms were then organized by support level for the small group that completed those reviews. This information was then entered into the *Pre-implementation Review Step 2 Packet* for that group.

At the beginning of Day 5, reviewers received the Step 2 training described above. Reviewers then divided into their small groups and reviewed the support need summaries for a given support level (1, 2, 3, M, or B). Reviewers took notes for that level using the Step 2 Reviewer Notes Form provided, noting any questions they had regarding the participant's support need as reflected in the summary. They were asked to look for similarities and difference in the amount of support need for participants in that support level and to identify any individuals they believed to require much less or much more general support, behavioral support, and/or medical support than others in the level. As part of this independent review reviewers were also asked to read the support level description for that level. Reviewers identified ways the description could be improved to reflect the support needs of individuals in that level, described what, if anything, was missing from this description, and identified if any parts of the draft description did not fit for the participants they reviewed.

Once reviewers completed their independent step 2 review, each small group reconvened and discussed the support need for that level. Through discussion the group reached consensus regarding whether they found that individuals in a given support level had similar support needs (strongly disagree to strongly agree) and determined if they identified any outliers for a given level. When outliers were identified these were grouped by those who had needs lower than the rest of the group and those who had needs higher than the rest of the group. Groups then identified the reasons why they classified a participant, or group of participants, as an outlier.

Once outliers were removed groups were again asked whether individuals in a given level had similar support needs, using the same scale. They were then asked to rate on a scale of 1 to 10 the amount of support the group, excluding outliers, requires in three areas (general support, behavior, medical conditions/therapies). Finally, groups discussed their review of the service description for that level reaching consensus on what recommendations to make for edits and adjustments.

This process was repeated for each support level reviewed by the group. Two groups reviewed a total of four levels (1, 2, 3, B) while one group reviewed all five levels. As there were only 11 participants available in Level M for review, these were all reviewed by one small group to allow for completion of the comparison required in Step 2.

Analysis

After the week of PIR data collection was complete, analysis began with data quality assurance, merging datasets from each PIR small group, and data cleaning. Additional data reduction and analysis took place afterwards, described below.

To ensure the accuracy of the data to be analyzed, an HSRI staff member outside the PIR small group staff members checked over each of the Step 1 forms. This staff member checked that the responses in the Step 1 forms corresponded to the responses entered into the dataset for analysis. Responses were deemed accurate to the forms if the meaning was retained in the dataset, rather than exact wording (e.g.,

if a reviewer noted a person needs 5 hours of adult day care support a week, the dataset may state "5 hr/wk" in the adult day care field. Any discrepancies were reviewed by the HSRI staff present in the PIR small groups. In a small number of instances, it was clear that the reviewer did not update their form after the small group reached consensus on a different response than their original one. The agreed upon response remained in the dataset in those instances.

Since each small group had one HSRI staff member entering data for the group, 3 datasets existed for Step 1 and 3 datasets existed for Step 2. Once all datasets were reviewed for accuracy, the Step 1 datasets were merged, and the Step 2 datasets were merged. Data cleaning for the analysis was minimal but involved some recoding of information to better summarize information (e.g., changing "none" to 0, "low" to 1, "high" to 3, etc.).

The first level of analysis occurred when reviewers filled out forms for each individual in the sample and groups agreed on the responses. This served as a preliminary level of coding. Once that coding was complete for a number of items, analyses further summarized information by support level for items on support need or by service mix and/or support level for items on service mix/budget. Descriptive statistics such as frequencies, percentages, and averages were used for all analyses of pre-coded information. Regarding support need, the analysis included summarizing for each support level the amount of support needed for different activities and the extent to which individuals in the same support level have similar support need. To further understand findings on support needs, all descriptive statistics on the coded data were conducted with outliers included and again with outliers excluded. Regarding service mixes and budgets, analysis included summarizing by service mix and support level the degree to which individual services and overall service mixes met the needs of the individuals. To present the descriptive statistics, we created graphs and/or tables to organize the information.

The analysis of open-ended items was necessary for only individuals in the sample who were deemed outliers and/or for whom the service mix/budget were deemed insufficient. These analyses allowed us to understand why individuals were outliers or why the service mixes/budgets were insufficient, which were goals of PIR. For these individuals, we read through the notes taken by HSRI staff on the conversations and responses of the small group, as well as returned to the notes written in Step 1 forms for the individual. For the analysis of outliers, we compiled notes on each individual that reflect why the reviewers believed their support needs did not match others in their assigned support level. We were able to summarize reasons based on those lists by drawing out themes based on the commonalities between individual outliers in the sample (e.g., behavior support needs greater than others in the level). A similar process occurred for individuals for whom the service mix was deemed inadequate. We compiled written responses on each individual by service mix and identified themes across individuals to report in the Findings section. Since all notes and open-ended responses were concise, no enhanced qualitative analysis was necessary beyond summarization and theme identification.

Lastly, HSRI staff met to confirm that the themes identified were reflective of all small group conversations and no important information was left out. For any unusual data in the datasets (e.g., a missing response to one question for an individual in the sample), staff discussed how to interpret and report on the finding. All analysis findings are described next in the Findings section.

Findings

To reflect the aims of PIR discussed in the Background section of this report, the findings are presented in the following sections on the 5-support level framework, support level descriptions, and service mixes/budgets. This section ends with a summary of the findings across all three areas of inquiry.

5-Support Level Framework

We first present the findings on support needs. Specifically, PIR was conducted to explore whether support needs increase from levels 1 through 3, whether adults in Levels M and B have extraordinary needs, and whether adults in the same support level have similar support needs. To explore these areas, we first present information on the outliers found in the sample, followed by findings on support needs by level and similarities in support needs by level.

Outliers

For the purposes of PIR, outliers are defined as those individuals who appear to need much less or much more support than others in the same support level. Information about outliers is helpful in answering the research question regarding whether adults in the same support level have similar support needs and helps to gain a better understanding about how the 5-level framework is performing overall. The 5-level framework is expected to assign individuals to the level commensurate with their need most of the time. We note that individuals with very unique needs or circumstances (e.g., recent change in need) may not be assigned to a level

commensurate with their need. Policies regarding reassessment and exceptions should be implemented in those instances.

Participants being identified as outliers could indicate that the framework was not operating as intended or could indicate that support level assignments for some individuals are not reflective of their support need for other identifiable reasons. Reviewers were instructed to provide detail as to the specific supports needs of the individual, the source of information cited as part of their support need determination, and to specifically detail when two records provided conflicting information regarding the individual's support need. This information was used to help specify the specific reasons why a given participant was identified as an outlier by the group of reviewers. While outliers are not the main focus of our inquiry into support need as reflected within the new resource allocation model they are discussed first because many of our support need analyses, discussed next, were conducting both including and excluding outliers.

Across the three groups of PIR reviewers, a total of 18 individuals were deemed "outliers." Ten of these individuals were deemed to require much more support than others in the same assigned support level and 8 individuals were deemed to require much less support than others in the same assigned support level. Each group provided detail as to the reasons why the participant appeared to need much more or much less support than others assigned to the same level and the following themes emerged.

Of those 10 participants whose needs were greater than the rest of their support level, all 10 were identified as requiring more behavior support than others in their assigned level, noting that the assigned level for each these individuals varied. Four of these individuals have behavioral support needs that were not reflected in the SIS-A which reviewers primarily attributed to increases in behavior support need since the SIS-A was completed. In all four circumstances, reviewers identified that the participant may qualify for assignment to Level B based on the support needs indicated throughout the rest of their record. One other individual also had changes in support need since the completion of their SIS-A, in this instance their extraordinary needs moved from being more medically-driven to being more behaviorally-driven causing their needs to looks significantly different than others assigned to Level M. The remaining 5 individuals had behavior support needs that were accurately reflected in their SIS-A responses, but which were simply greater than others assigned to that same level. These were not behavior support needs that were sufficient to qualify for a different support level (e.g., a move to Level B) but which were beyond the behavior support needs of others in the same level.

The reasons why the 8 individuals who were identified as needing less support than others in the same assigned level varied, but again common themes emerged. Four of these individuals also had needs that changed since the time their SIS-A was conducted. For 3 individuals this change was a significant decrease in their behavior support needs which reviewers identified may no longer meet the criteria for Level B. For 1 individual, this change was a marked decrease in seizure activity since the time

of the SIS-A and medical support needs did not rise to the same level as other individuals also assigned to Level M. The 4 remaining individuals appeared to have lower general support needs than others in their assigned level, however, this was not specifically identified as being the result of a change in support need since the SIS-A was completed. In all four cases reviewers felt the general support needs of these individuals better aligned with the support need of individuals assigned to a lower support level.

In total for 9 of the 18 individuals identified as outliers, the cause of this designation was directly tied to a change in support need since the time the SIS-A was completed. Because the SIS-As used to make preliminary level assignments were completed in 2017 and 2018 and PIR was conducted in March 2021 this change in support need is not unexpected.

The 5 remaining individuals with support needs greater than others in their assigned level did not appear to meet the criteria for another level on the basis of this higher behavior support need thereby not indicating a specific issue with how participants are assigned to levels. While the behavior support needs of these individuals may be greater than others in the PIR sample this may simply be an indication of a particularly narrow range of behavior support needs within the sample reviewed by a given group.

As described in the Approach section of this report, the sample for this qualitative inquiry is not meant to be representative of the population overall, but to provide in-depth information from a small sample. This means the full range of support needs for behaviors may not be present in the PIR sample. Similarly, the 4 individuals identified as outliers due to having lower general support needs than others in the same group may truly need much less support than others in that level or the range of general support needs reflected in the record reviewed by a given group could be somewhat narrower than is reflective of the true range anticipated by the level criteria.

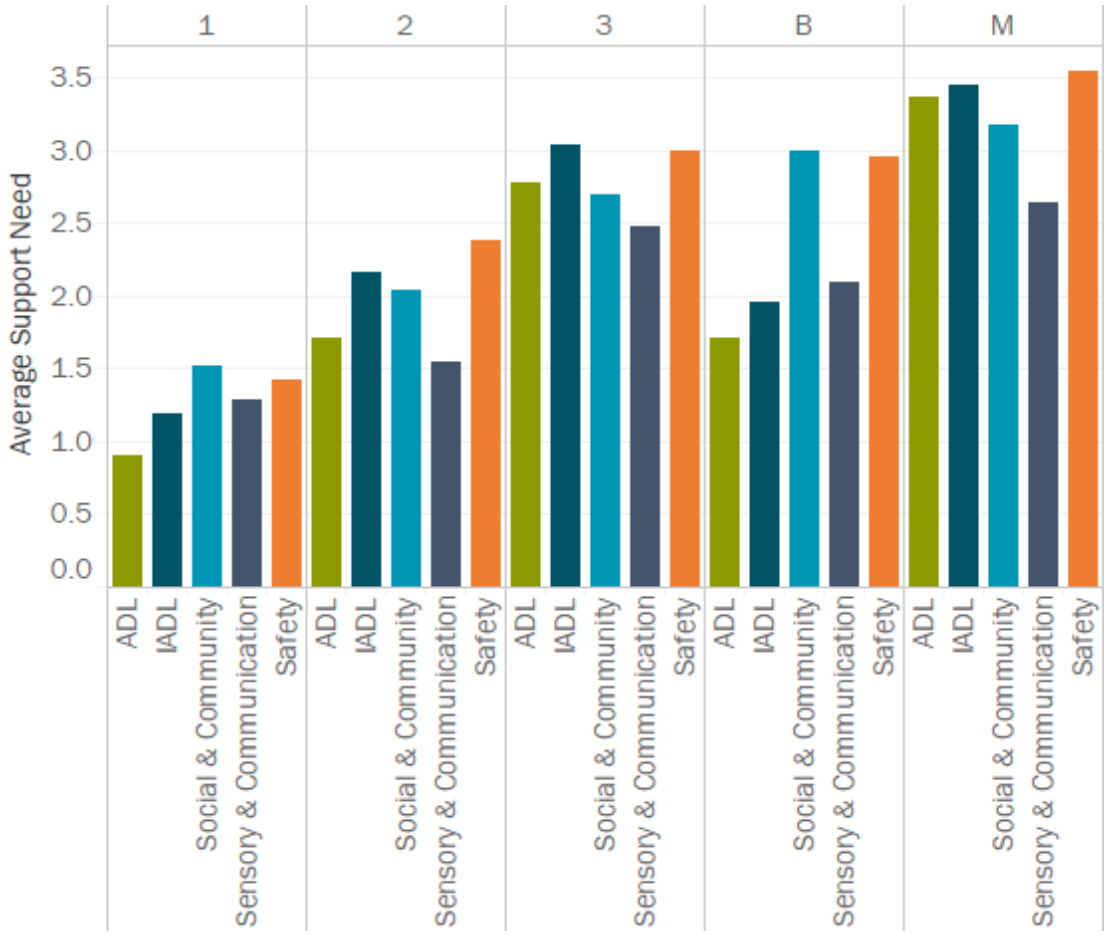
General support needs

HSRI defines general support as those types of supports that are required to complete the typical day to day activities of anyone living and interacting in their community. This encompasses support to complete activities such as eating, bathing, and dressing (i.e., Activities of Daily Living (ADLs)), as well as preparing meals, completing household chores, or making necessary purchases (i.e., Instrumental Activities of Daily Living (IADLs)). General support also includes the assistance someone needs to socialize and participate in recreation in their community, communicate their wants and needs, and remain generally safe such as the support needed to evacuate in the event of an emergency.

Ascertaining the amount of general support needed by participants, by level, allows us to determine whether general support needs do in fact increase from Levels 1 through 3 as intended and to get a better picture of the general support needs of adults assigned to levels due to their extraordinary behavioral and medical support needs.

Reviewers were asked to rate the amount of support each participant needed (none, low, moderate, high, or extensive) across five domains of general support. Figure 8 shows the average rating (on a scale of 0-4, ranging from none to extensive) for each type of general support by assigned support level.

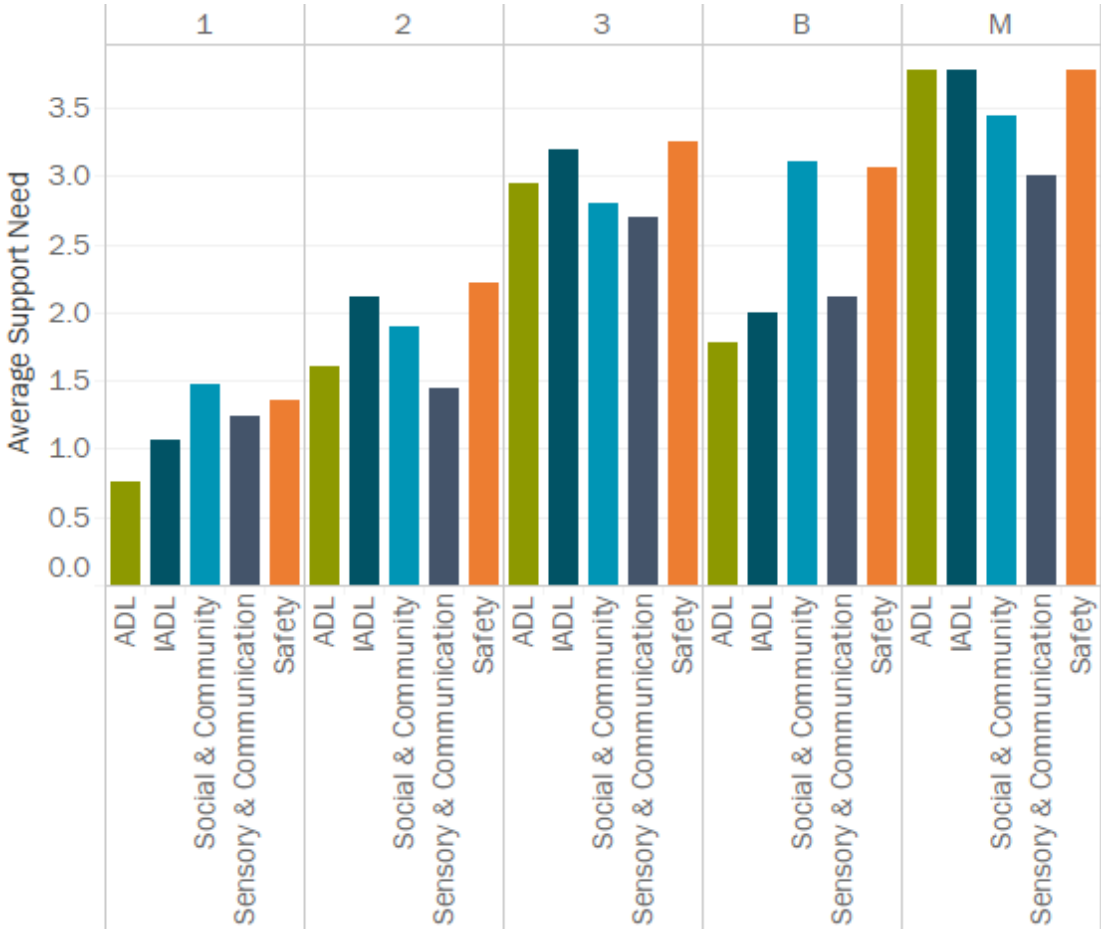
Figure 8. Support needed across general support need areas by level (n = 100)



Across all participants included in the PIR sample, the average ratings increase in all domains as level increases, 1 through 3. The amount of support needed in each of these five areas vary within each level, but all trend upward when looking across levels. For example, support for social and community activities the highest rated for Level 1 but is one of lowest rated within Level 3 despite increasing in each level. The general support need ratings for participants assigned to Level B vary the most significantly, with the average ratings for social and community support and safety support being nearly a full point higher than ratings in the other three areas. Individuals assigned to Level M had the highest ratings in all five areas of general support with individuals requiring high to extraordinary support in all areas except communication.

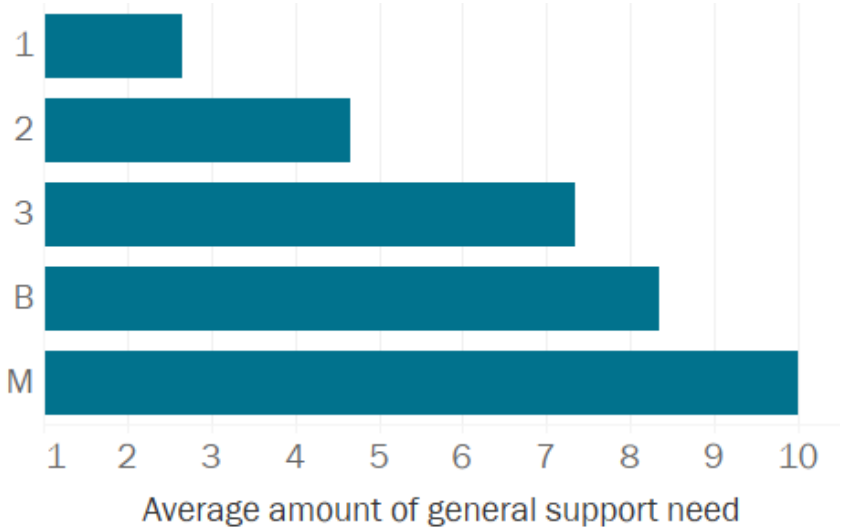
We next reviewed the same information with all individuals identified as outliers removed. Here too the scale ranged from 0-4 with response options of none, low, moderate, high, or extensive. As shown in Figure 9 the difference in average scores was very minor with most scores slightly lower once outliers were removed.

Figure 9. Support needed across general support need areas by level, outliers removed (n = 82)



During Step 2 of PIR reviewers were asked to rate the overall general support need of the membership of a given level on a scale of 1 to 10 (low to high). This rating was done on the level as a whole with outliers removed. The figure below shows the average rating across the three review groups for Levels 1, 2, 3, and B and shows the rating of one group for Level M as only one group completed review for individuals in Level M. General support need as rated by PIR reviewers increases by level, with Levels B and M rated as having the highest support needs.

Figure 10. General support need by level on scale of 1 to 10, outliers removed



Extraordinary support needs

While participants in every level require support for behavior and medical needs, the 5-level framework provides two levels specifically for those individuals who require extraordinary support in these areas. Behavior support need is defined as the support a person requires beyond what is needed for general support needs specifically to prevent, manage, and/or intervene on behaviors that may result in harm to self, others, or property. Medical support need is defined as the support a person requires beyond what is needed for general support needs, specifically therapies, medications, and/or treatments for medical conditions.

Assignment to these levels will be different than the process of being assigned to Levels 1, 2, or 3. Participants who believes they have the type of support envisioned for Levels M or B, or who were identified as potentially having that type of support need during the SIS-A assessment, are given an opportunity to submit documentation detailing their medical or behavioral support need for review by the Verification Team. The Verification Team then reviews this documentation determining whether a given participant meets the criteria for these levels as stated in rule. Note that when preliminary level assignments were made for the first cohort only those participants who were identified during the SIS-A assessment as potentially having the type of support need applicable for Levels M or B were reviewed by the Verification Team. Once the new resource allocation is implemented participants will also have the opportunity to request such review.

One aim of PIR was to determine whether those adults assigned to Levels M and B (and only adults assigned to Levels M and B) have extraordinary need for medical or behavioral support, respectively. Only those participants choosing Supported Living Services for their residential habitation supports have experience using a process similar to verification. Therefore, particular attention is needed to ensure all participants who have the types of support need envisioned for Levels M and B are traversing the new verification process and being assigned appropriately.

By identifying the amount of behavior and medical support need determined by reviewers for each level, we are able to explore whether only those participants assigned to Levels M and B were rated as having extraordinary support need in these areas. These responses also provide insight into the level of behavior and medical support need typical among the members of other levels. This allows development of a fuller picture of the full support need profile typical of adults at each level.

During Step 1 of PIR reviewers were asked to rate the amount of support each participant needed (none, low, moderate, high, or extensive) for both behavioral and medical support. At the time these ratings were decided reviewers did not know the level to which the participant was assigned. Figure 11 shows the average rating (on a scale from 0-4) for medical and behavioral support, by assigned level, for all individuals reviewed as part of PIR. As the figure shows, ratings increase for behavior support need steadily from Levels 1 to 3 with a significant jump in support need in Level B. The ratings for medical support also increase slightly from Levels 1 to 3 with another significant increase in medical support need for Level M. The average rating for behavior support in Levels 1 to 3 is higher than the average rating for medical support.

Figure 11. Support needed across behavior and medical support need by level (n = 100)

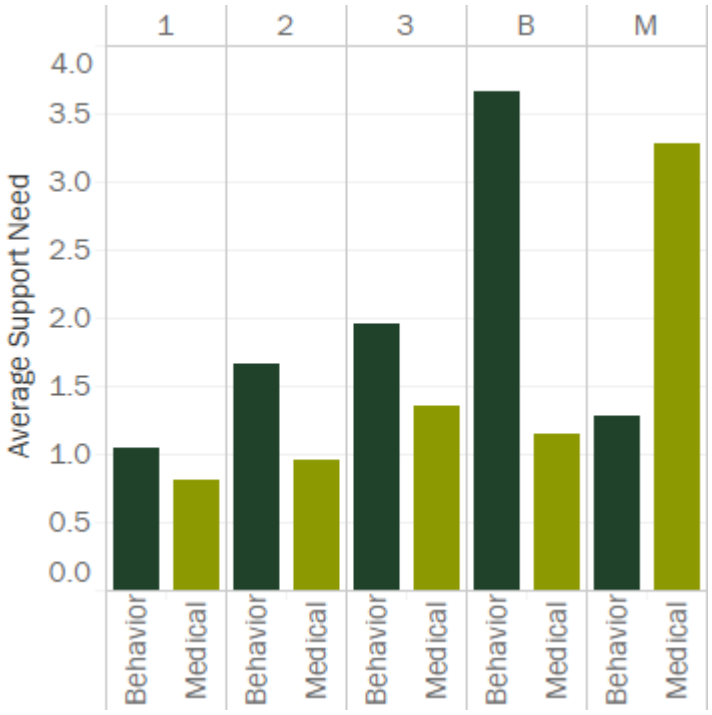
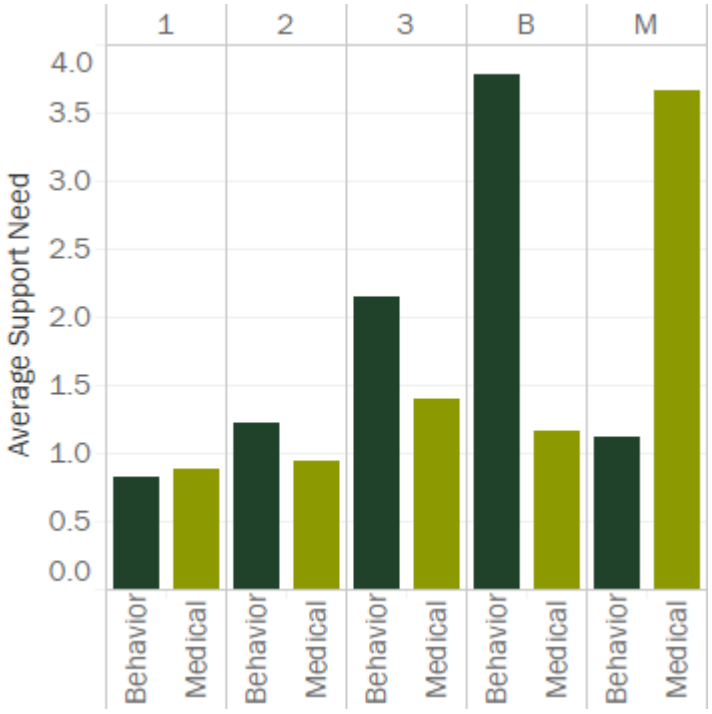


Figure 12 provides the same information with outliers removed. Scores for behavioral support decrease slightly for Levels 1, 2, B, and M as would be expected considering the justification reviewers provided for designating individuals as outliers (e.g., having behavior support need significantly greater than others assigned to the same level). Scores for medical support remain relatively stable with outliers removed

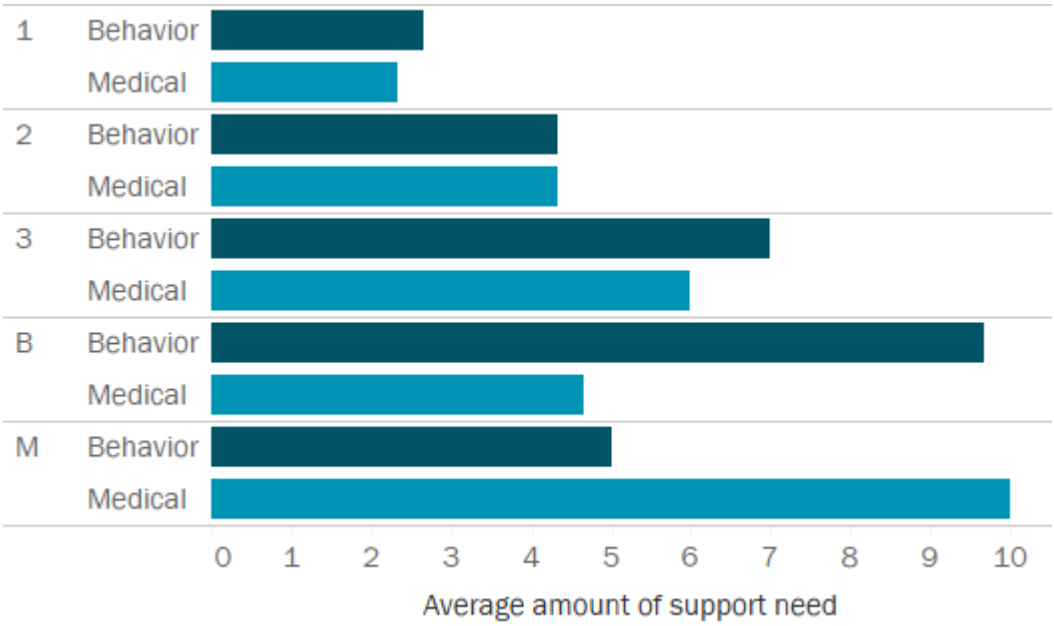
except in Level M which increases due to the removal of outliers identified as having lower medical need.

Figure 12. Support needed across behavior and medical support need by level, outliers removed (n = 82)



In addition to rating medical and behavioral support need at the individual level, reviewers were asked as part of Step 2 to consider the behavior and medical support need of each level as a whole. As a group, reviewers rated the medical and behavioral support need on a scale of 1 to 10 (low to high) for each level after removing outliers. Figure 13 shows the average rating across the three review groups for Levels 1, 2, 3, and B and shows the rating of one group for Level M as only one group completed reviews for individuals in Level M. Both medical and behavior support need increased from Levels 1 to 3 when viewing the level as a whole. Behavior support had an average rating of 10 for Level B and medical support was rated a 10 for Level M (the highest rating possible). These rating were three to four points higher than the rating in any other level for these areas of support need indicating that reviewers found much higher medical and behavioral support need in Levels M and B, respectively, than in other levels.

Figure 13. Behavior and medical support need by level on scale of 1 to 10, outliers removed



Similar support needs

One of the specific research questions set out as part of PIR was to determine whether adults in the same support level have similar support needs. While this question can be investigated in part by reviewing the individual support need ratings across individuals assigned to the same level, we would not expect identical scoring in each domain of support. The aim of the 5-level framework is to group individuals with similar support needs based on that totality of their needs, understanding that the specific combination of needs or particular areas of need will vary person by person. Therefore, PIR asked reviewers to identify whether they agreed that individuals in each support level have similar support needs following their review of the membership of each level as a whole.

The question on similarity of support needs within a support level was posed to reviewers both with outliers included and again with outliers excluded. Figure 14 shows the rating provided by each group of reviewers. Note only one group reviewed records for participants assigned to Level M. With outliers included groups agreed, but did not strongly agree, that individuals in Levels 3, B, and M had similar support needs. One group disagreed that that the support needs of participants were similar in Levels 1 and 2 while the two other groups agreed. Once outliers were removed all groups agreed, or strongly agreed, that individuals in each level had similar support needs.

Figure 14. PIR review groups rating of the extent to which individuals in each support level have similar support needs

OUTLIERS INCLUDED					
	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	TOTAL
1		1	2		3
2		1	2		3
3			3		3
B			3		3
M			1		1

OUTLIERS EXCLUDED					
	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	TOTAL
1			2	1	3
2			1	2	3
3			1	2	3
B			1	2	3
M				1	1

Our findings next describe the support level descriptions. For an overall review of PIR findings related to support need please see the Summary of Findings starting on page 52.

Level Descriptions

During Step 2 of PIR, reviewers examined the draft level descriptions and through a collaborative discussion process determined whether the support needs of individuals assigned to each level were accurately reflected. Three groups reviewed the description for Levels 1, 2, 3, and B and one group reviewed the description for Level M. None of the groups identified specific areas where a description was inaccurate for a given level but had various recommendations regarding how to expand upon the descriptions and improve their understandability.

Groups noted a desire to see reference to the medical and behavioral support needs typical of each level noting that these needs are not limited to those who require extraordinary support and do factor into the overall needs of participants at every level. Groups recommending adjusting descriptions to move away from terms like “a lot” or “some part of the day” where possible as they may be difficult to quantify. Groups suggested defining all terms where possible and adding more detail regarding whether supports for individuals in a given level could be successfully provided in a group setting or whether substantial amounts of one-on-one support would be typical of participants in that level.

Using this feedback as a guide, HSRI revised the draft level descriptions. We revised the descriptions based on all feedback, where possible. See the Recommendations section of this report for those revised descriptions.

Service Mixes and Budgets

In addition to exploring the 5-level framework and level descriptions, PIR sought to determine whether the service mixes and budgets proposed by DHW are generally adequate in each support level. Because the individual services within a mix and the resulting budget are specific to the type of residential habilitation support the participant selects and the way they choose to obtain their services (i.e., Traditional or Self-Direction), this section is divided by service mix to allow for a more in-depth inquiry into the adequacy of each specific service mix. As noted above, as no participants within the sample would receive the State Plan HCBS Only service mix or the Self-Directed with No Residential Habilitation Community Support Services mix these mixes are not included in this Findings section.

Due to the specific nuances involved in understanding why a service mix is or is not adequate for a participant assigned to a given level, this section provides primarily narrative descriptions regarding those circumstances where a service mix was identified as being insufficient to meet a participant's needs. For all mixes, HSRI analyzed the sufficiency of the mix overall, as rated by reviewers. However, information about the adequacy of individual services within the mix was only collected and analyzed for traditional service mixes as the specific services included in the mix are not utilized by participants in self-direction thereby making it difficult to gauge whether a given service would or would not meet that individual's need.

Across all traditional service mixes reviewed (CFH, SLS, Non-Residential), reviewers identified the mix would meet the needs of the participant 82% of the time. Across the self-directed service mixes reviewed (SD (like CFH), SD (like SLS)) reviewers identified the mix would meet the needs of participants 45% of the time.

Certified Family Home Service Mix

The Certified Family Home Service Mix is intended for any participant who uses the traditional pathway for service and has elected to receive residential habilitation supports from a CFH provider. As shown in Figure 15, the proposed CFH service mix was rated by reviewers as completely meeting the needs of all but one participant reviewed within this service mix. Note that outliers were not removed from this analysis but are identified below where applicable and helpful in understanding the reasons why a service mix was identified as being insufficient to meet the participant's needs. For full detail regarding what services in what amounts comprise this mix by level, see the Appendix of this report.

Figure 15. Overall CFH service mix meets needs (n = 15)

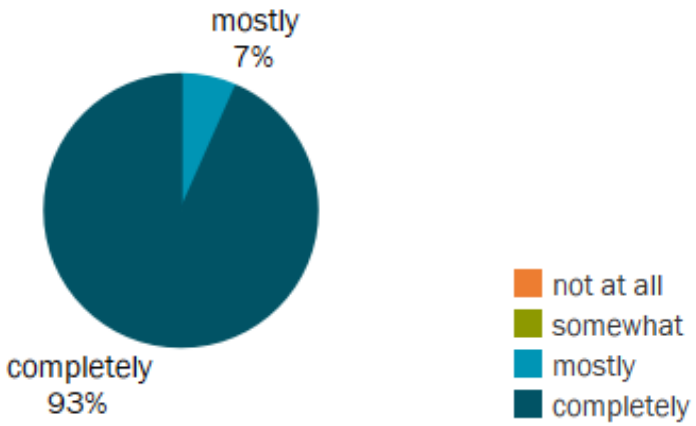


Figure 16 provides additional detail regarding how reviewers rated the sufficiency of the service mix by participant. This table shows, by assigned support level, the adequacy of the CFH service mix. Note that as no participants assigned to Level B within the sample would receive the CFH service mix that level is missing in the figures below. Reviewers found the applicable service mix to completely meet the needs of all but one participant. That participant was assigned to Level 2. Reviewers identified that the individual whose needs would be mostly, but not completely, met by the proposed service mix would likely want more adult day health and center-based developmental therapy than the mix offers. When the amount of these services reviewers identified the adult would prefer were added, the total value of the budget would increase slightly beyond the available budget for Level 2.

Figure 16. Overall CFH service mix meets needs

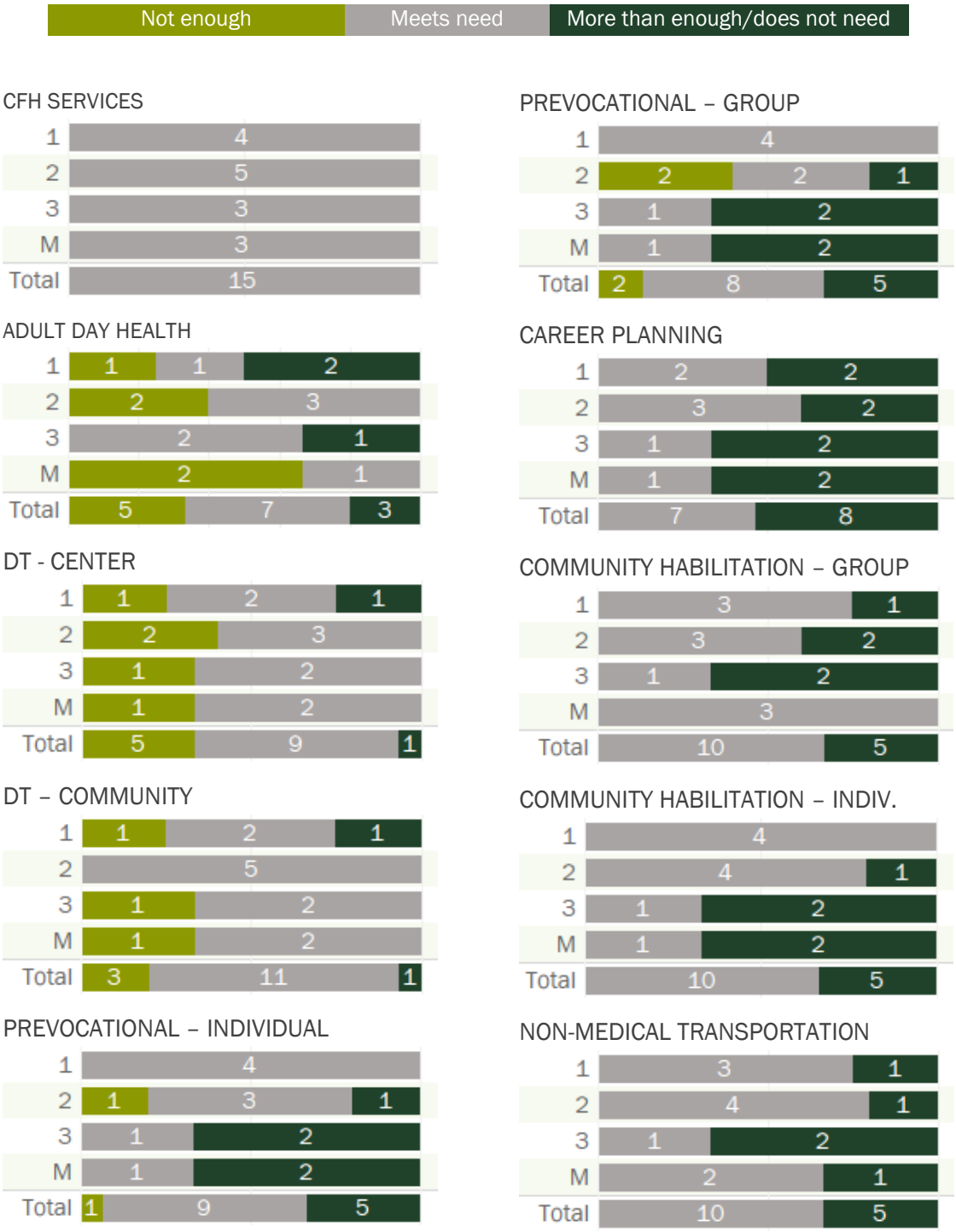
LEVEL	MEETS NEEDS	n
1	Completely	4
	LEVEL TOTAL	4
2	Mostly	1
	Completely	4
	LEVEL TOTAL	5
3	Completely	3
	LEVEL TOTAL	3
M	Completely	3
	LEVEL TOTAL	3
TOTAL		15

Reviewers were also asked to identify, service by service, whether the number of hours in the proposed service mix for that level would meet the need of each participant. While the service mix is not prescriptive—meaning that individuals may

use their budget dollars to purchase the combination of services within the mix that best meet their need—this inquiry allowed for insight into whether adjustments to the specific services in the mix would better reflect potential service need. While variability among participants is expected, strong trends showing that the number of hours for a particular service are not enough or are not needed could indicate areas where adjustment to the mix may be warranted, regardless of the overall sufficiency of the budget.

Figure 17 shows, by each service included in the mix, how participants rated the number of hours in the proposed mix. Two response options ("more than enough" and "does not need") were combined in this analysis to facilitate interpretation of the findings since both options indicate that the services were more than needed. Two services (targeted service coordination and plan development) are not included as in all instances, and for all service mixes, reviewers identified the number of hours available within the mix to meet participant need. The amount of those two services afforded in the service mix is standard across all mixes at all levels.

Figure 17. Model CFH service mix hours meet need by level (n = 15)



Supported Living Service Mix

The Supported Living Service Mix is intended for any participant who uses the traditional pathway for service and has chosen to receive residential habilitation supports from an SLS provider. As shown by Figure 18, the proposed SLS service mix was rated by reviewers as completely meeting the needs of 81% of participants

reviewed in this mix, mostly or somewhat meeting the needs for 8% of participants, respectively, and rated as not at all meeting the need for 4% of participants whose records were reviewed within this mix. Outliers were not removed from this analysis but are identified below where applicable and helpful in understanding the reasons why a service mix was identified as being insufficient to meet the participant's needs. For full detail regarding what services in what amounts comprise this mix by level, see the Appendix of this report.

Figure 18. Overall SLS service mix meets needs (n = 53)

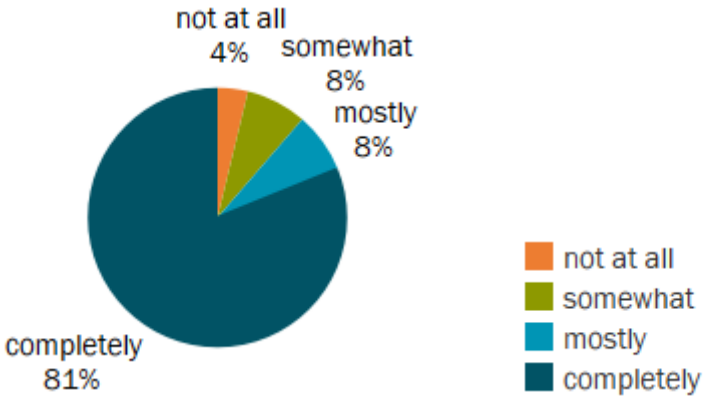


Figure 19 shows, by assigned support level, the adequacy of the SLS service mix. Reviewers identified that the available service mix did not all meet the needs of 2 participants, one assigned to Level 2 and one assigned to Level 3. Reviewers identified the overall service mix somewhat met the need of 1 of the participants at Level 1 and 3 of the participants at Level 2. For 4 participants, one at Level 1, one at Level 3, and one at Level B, the service mix was identified as mostly meeting the need. For the remaining 43 participants reviewed within this service mix, reviewers identified the mix completely met the need.

Figure 19. Overall supported living service mix meets needs

LEVEL	MEETS NEEDS	n
1	Somewhat	1
	Mostly	1
	Completely	9
	LEVEL TOTAL	11
2	Not at all	1
	Somewhat	3
	Completely	4
	LEVEL TOTAL	8
3	Not at all	1
	Mostly	1
	Completely	6
	LEVEL TOTAL	8
B	Mostly	2
	Completely	18
	LEVEL TOTAL	20
M	Completely	6
	LEVEL TOTAL	6
TOTAL		53

For three of the participants (2 at Level B and 1 at Level 3) whose needs could mostly be met within the budget reviewers identified that the adult would need to live alone due to having challenging behaviors when living with a roommate. However, the SLS service mix at Levels 3 and B do not offer adequate funds for 24 hour 1:1 support. Reviewers noted that while those participants assigned to Level B would have sufficient budget to receive 18 hours a day of 1:1 support and did not have behavior support needs which specifically required 1:1 support during typical sleeping hours, the inability to successfully live with a roommate made overnight staff sharing logistically infeasible. The remaining participant who reviewers felt would receive a budget that would mostly meet their need was identified as needing 24-hour support which their Level 1 budget would not provide. This participant was also deemed an outlier by reviewers due to their level of need for behavior support.

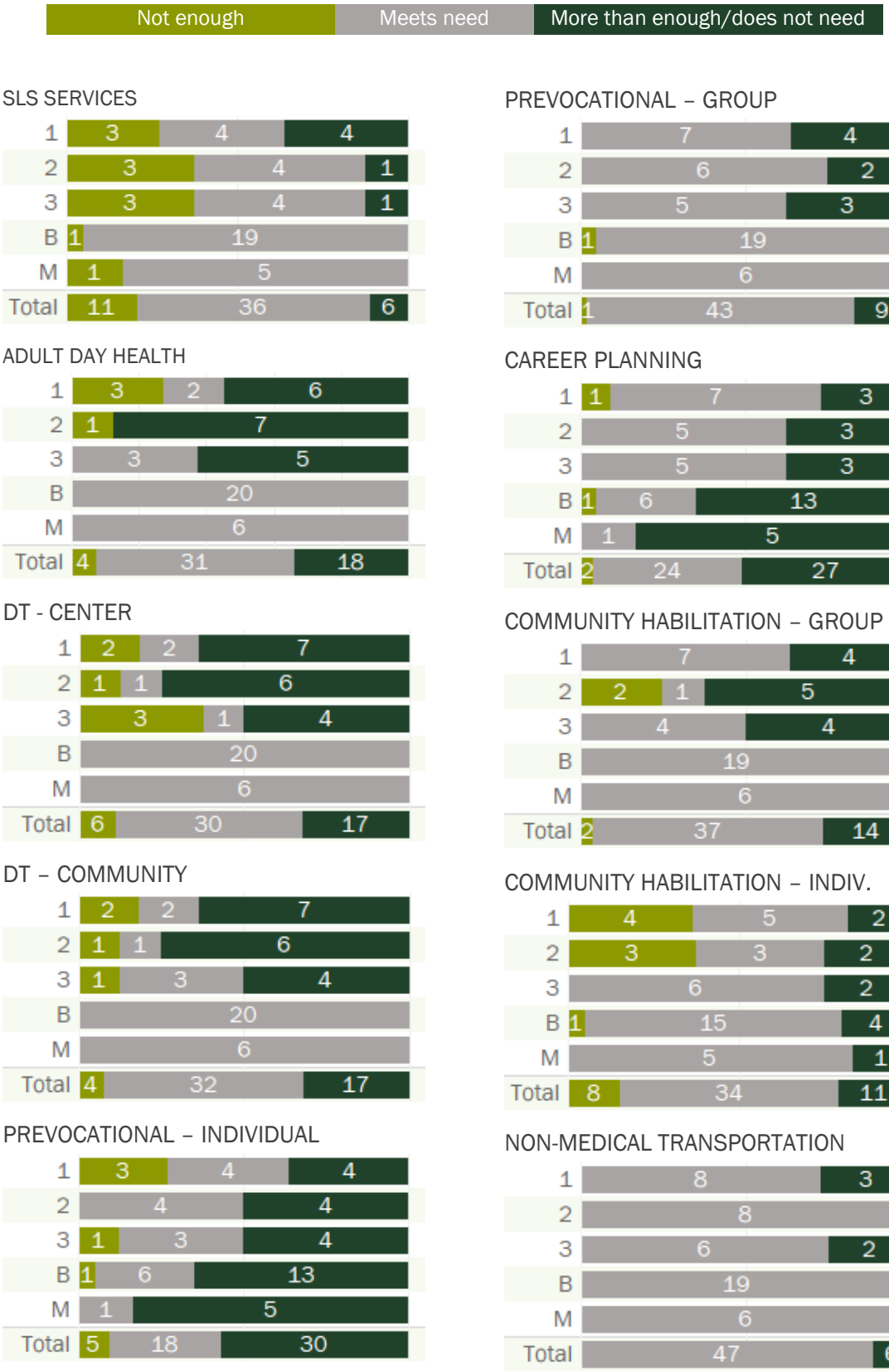
Three participants identified as outliers due to their behavior support needs were also identified as having budgets that would only somewhat meet their needs. One participant requires 24-hour support not available in Level 1, another participant

requires regular 1:1 support not available within the SLS budget for Level 2, while the third requires 1:1 support for behavior 24 hours a day, which requires a budget higher than any of the levels provide. One additional participant was identified by reviewers as receiving a budget that would only somewhat meet their needs due to having needs and interests which better align with community habilitation services for more than 40 hours/week which is not possible within the available budget.

One participant assigned to Level 2 was identified as an outlier who would likely meet the criteria for Level B and reviewers identified a Level 2 budget would not at all meet their needs, although noted a Level B budget would be fully adequate. One additional participant was identified as having a budget that would not at all meet their needs due to requiring more 1:1 supported living services than were factored into the mix for Level 3.

Reviewers were also asked to identify, service by service, whether the number of hours in the proposed service mix for that level would meet the need of each participant. Figure 20 shows, by each service included in the mix, how participants rated the number of hours in the proposed mix. Two response options (more than enough and does not need) were combined in this analysis to facilitate interpretation of the findings. Across the services reviewed, for the majority of participants the amount of service in the mix was identified as meeting the need of participants. For every service other than non-medical transportation, the amount of service in the mix was also insufficient for some participants while being more than enough or not needed by other participants.

Figure 20. Model SLS service mix hours meet need by level (n = 53)



No Paid Residential Habilitation Supports Service Mix

This service mix is intended for any participant using the traditional pathway who chooses not to use paid residential habilitation supports. Individuals assigned to this service mix may not require residential support or may choose to rely on unpaid natural supports to meet those needs. If in the future participants assigned to this service mix were to elect to receive paid residential habilitation supports, they would transition to another service mixes (i.e., CFH or SLS). As shown by Figure 21 the proposed non-residential service mix was rated by reviewers as completely meeting the needs of 73% of participants reviewed in this mix, mostly meeting the needs for 9% of participants, and rated as somewhat meeting the need for 18% of participants whose records were reviewed within this mix. Note that one participant assigned to this service mix is not included in the total for Figures 21 or 22. One group of reviewers did not respond to this question for a participant, noting that they believe the person would benefit from SLS rather than the non-residential service mix. They noted that if the individual was in SLS the service mix would be completely adequate. For full detail regarding what services in what amounts comprise this mix by level, see the Appendix of this report.

Figure 21. Overall non-residential service mix meets needs (n = 11)

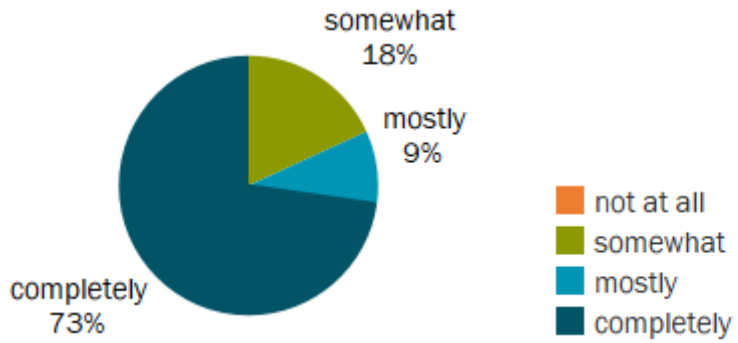


Figure 22 shows, by assigned support level, the adequacy of the non-residential service mix. Note that as no participants assigned to Level B within the sample would receive the non-residential service mix that level is missing in the figures below. Reviewers identified that the available service mix would somewhat meet the need for two participants, one assigned to Level 1 and one assigned to Level 2. The mix would mostly meet the needs of 1 participant in Level 1 and would completely meet the need for the 8 remaining participants rated by reviewers.

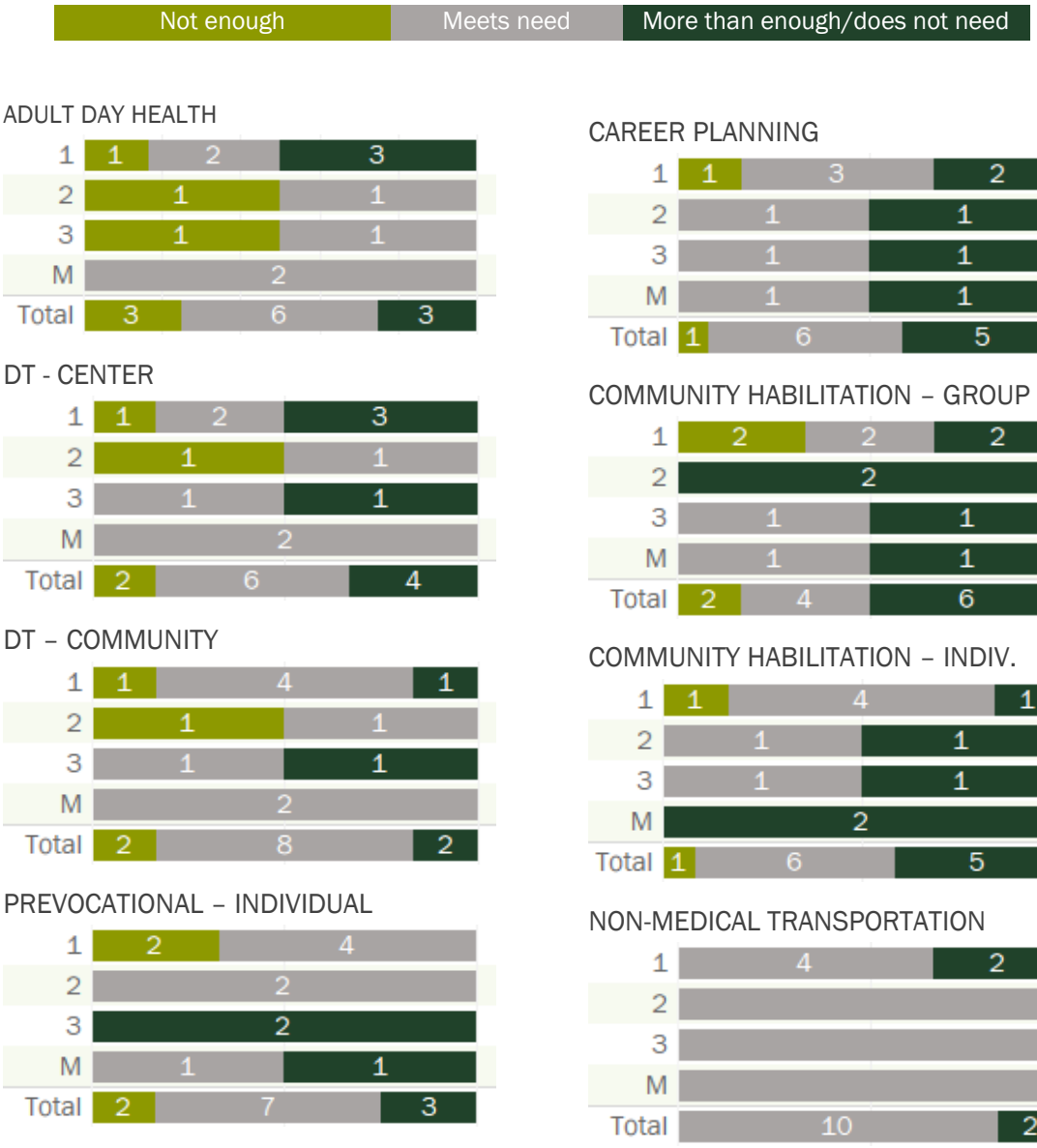
Two of the adults reviewers felt required more support than was available within the mix would benefit from additional access to day supports such as Adult Day Health and Developmental Therapy, both center-based and community. One adult would also benefit from respite services which are not specifically delineated within the service mix. Reviewers identified that a third participant would benefit from hours of support in the home, in the form of SLS, which is not available within this service mix.

Figure 22. Overall non-residential service mix meets needs

LEVEL	MEETS NEEDS	n
1	Somewhat	1
	Mostly	1
	Completely	3
	LEVEL TOTAL	5
2	Somewhat	1
	Completely	1
	LEVEL TOTAL	2
3	Completely	2
	LEVEL TOTAL	2
M	Completely	2
	LEVEL TOTAL	2
TOTAL		11

Reviewers were also asked to identify, service by service, whether the number of hours in the proposed service mix would meet the need of each participant. Figure 23 shows, by each service included in the mix, how participants rated the number of hours in the proposed mix. Two response options (more than enough and does not need) were combined in this analysis to facilitate interpretation of the findings. Across the services reviewed, for the majority of participants the amount of service in the mix was identified as meeting the need of participants. For every service, other than non-medical transportation, the amount of service in the mix was also insufficient for some participants while being more than enough or not needed by other participants. Note that one additional participant is included in the figure below as reviewers provided responses to this question for all participants assigned to this service mix.

Figure 23. Model non-residential service mix hours meet need by level (n = 12)



Self-Directed Service Mixes

At the time of PIR, the exact process by which a participant who self-directs their supports would be assigned to a particular service mix was still undefined, thereby making the task of identifying whether the applicable service mix and budget would meet the participant's need more difficult. Reviewers were asked to identify which self-directed service seemed most likely to apply given the detail available at that

time. Reviewers identified participants as qualifying for the self-directed CFH-like service mix when they received supports from the person they lived with in an arrangement that was affirmatively described as, or appeared analogous to, a traditional CFH. Reviewers identified a participant as qualifying for the self-directed supported-living like service mix when they received supports in their home from someone who did not live in the home or when the participant owned or had control of the residence they shared with those people providing their support. Guidance from DHW around how service mixes will apply to adults who self-direct is still forthcoming and once finalized could result in some of the adults who reviewers identified as likely qualifying for the self-directed SLS-like service mix being assigned another mix instead. Please keep this in mind when reviewing the findings in the following sections.

As described earlier in this report, difference between the traditional pathway and self-direction make direct application of the service mix difficult. Adults using self-direction build support and spending plans using ten categories which can be flexibly used to allocate the participant's supports dollars in a variety of ways. While each service within traditional supports has a clearly defined service definition, two adults self-directing may receive seemingly analogous supports allocated to different categories. For these reasons when reviewers conducted their review of the adequacy of the available service mixes it primarily focused on the ampleness of the overall budget to obtain the kinds of supports which had been shown to meet the participant's wants and needs. Reviewers were not asked to identify whether the individual hours of services within the mix were adequate for these participants because the way they use services is so different than on traditional.

In the following sections we detail reviewers' findings regarding the adequacy of the budget available for participants who self-direct.

Self-Directed Certified Family Home-Like Service Mix

As shown in Figure 24, the proposed self-directed CFH-like service mix was found by reviewers to completely meet the needs of 31% of participants reviewed in this mix and mostly, somewhat, or not at all meet the needs for 23% of participants, respectively.

Figure 24. Overall self-directed CFH-like service mix meets needs (n = 13)

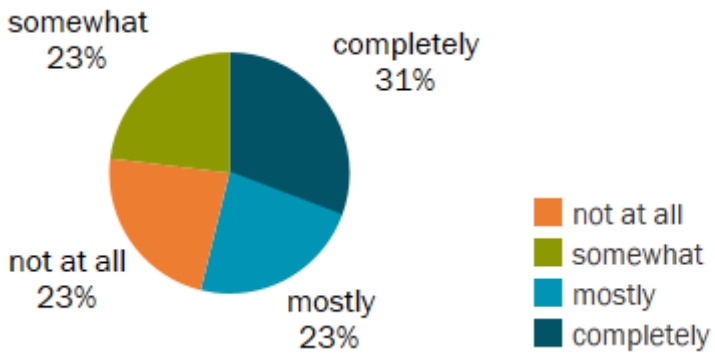


Figure 25 shows, by assigned support level, the adequacy of the self-directed CFH-like service mix. Note that only participants assigned to Levels 2 and 3 within the sample were identified as receiving this mix so Levels 1, B, and M are excluded from the figure below. Reviewers identified that 4 participants, two in Level 2 and two in Level 3, would have their needs completely met by the mix.

Figure 25. Overall self-directed CFH-like service mix meets needs

LEVEL	MEETS NEEDS	n
2	Not at all	2
	Somewhat	1
	Mostly	2
	Completely	2
	LEVEL TOTAL	7
3	Not at all	1
	Somewhat	2
	Mostly	1
	Completely	2
	LEVEL TOTAL	6
TOTAL		13

Those three adults identified as having their needs mostly met by the available mix each needed slightly more funds than the proposed budget offered to allow them to continue receiving the weekly personal, emotional, and learning supports they have been accessing and appear to need. Reviewers also noted that for two of these individuals they would also require additional funds, outside of the budget, to continue receiving current necessary job supports.

Reviewers identified that three participants would have their needs somewhat met within the proposed budget but have been receiving and benefiting from services beyond what the service mix would afford. Additional needed supports were focused in the areas of personal and learning support. When calculated, reviewers identified a need for between $20,000 and $40,000 additional dollars to obtain the identified supports. The general need for simply more budget than is offered in the proposed service mixes was similarly identified for those participants who were identified as having needs that were not at all met by the service mix. These individuals were identified as requiring between 9 and 12 hours a day of support, all of which must be provided 1:1 based on the rules of the self-direction program, and which the budget for self-directed CFH-like would not afford.

Self-Directed Supported Living Services-Like Service Mix

As shown in Figure 26, the proposed self-directed SLS-like service mix was found by reviewers to completely meet the needs of 71% of participants reviewed in this mix and somewhat or not at all meet the needs for 14% of participants, respectively.

Figure 26. Overall self-directed SLS-like service mix meets needs (n = 7)

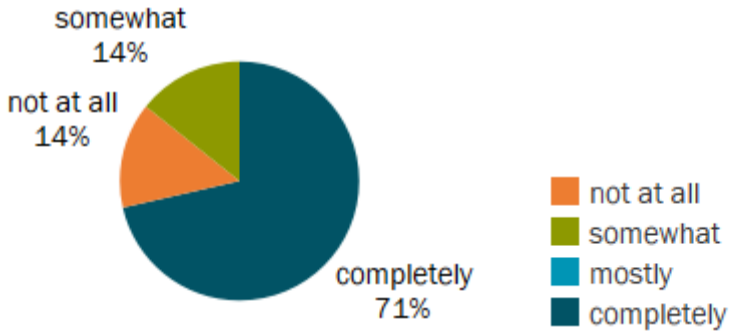


Figure 27 shows, by assigned support level, the adequacy of the self-directed SLS-like service mix. Note that no participants assigned to Levels 1 or M within the sample were identified as receiving this mix and are therefore excluded from the figure below. Of the seven participants reviewed within this service mix, reviewers identified that 5 would have their needs completed met by the mix.

Figure 27. Overall self-directed SLS-like service mix meets needs

LEVEL	MEETS NEEDS	n
2	Somewhat	1
	Completely	1
	LEVEL TOTAL	2
3	Not at all	1
	Completely	3
	LEVEL TOTAL	4
B	Completely	1
	LEVEL TOTAL	1
TOTAL		7

Reviewers identified that one participant assigned to Level 2 would only somewhat have their needs met by this service mix as they would likely want and need a combination of services that would cost approximately $30,000 more than is available within the budget for that level. Reviewers also identified that one participant who requires 24 hours of paid 1:1 support has needs that would not at all be met by the proposed service mix.

Summary of Findings

PIR aimed to explore the 5-level framework, support level descriptions, and service mixes/budgets. This section reviews the research questions associated with each of those resource allocation elements then summarizes the respective findings.

Findings on 5-support level framework

We sought to explore three research questions related to the 5-support level framework:

1. Do general support needs increase from Levels 1 through 3?
2. Do adults assigned to Levels M and B (and only adults assigned to Levels M and B) have extraordinary need for medical support or behavioral support, respectively?
3. Do adults in the same support level have similar support needs?

Findings indicate that general support needs increase from Levels 1 through Levels 3. While different areas of general support need (e.g., IADLs) require different amounts of support need for individuals in the sample, each individual area increases by level. This finding is true both with outliers included and excluded. When considering the amount of general support of all individuals reviewed in each level, the amount of general support needed also increase from Level 1 through Level 3.

Findings indicate that adults assigned to Levels M and B do have extraordinary support need. Few individuals in those levels were deemed to have less than extraordinary support need, but reasons were most often identified why the level assignment may have occurred (e.g., a change in medical condition that no longer merits extraordinary support). Some individuals in Levels 1 through 3 were deemed to have some amount of behavioral support need, but findings indicate they would not merit extraordinary support for those needs. In instances where level assignment seemed to not reflect support need for medical or behavioral needs, findings indicate a reassessment may resolve the discrepancy.

Lastly, findings indicate that, for the most part, adults in the same support level have similar support needs. While some outliers exist, there are identifiable reasons why such outliers exist. The Recommendations section of this report describes some ways in which the existence of outliers may be reduced or addressed in ways outside of the SIS-A assessment. Once outliers were removed, findings indicate that adults in the same support level in the sample all have similar support needs.

Findings on support level descriptions

We sought to explore two research questions regarding the support level descriptions:

1. Do descriptions reflect the support needs of individuals in each of the 5 support levels?
2. How can descriptions be improved for accuracy or understandability?

Across all support levels, reviewers agreed that descriptions reflected the overall needs of individuals in the level. Some changes were suggested to improve the accuracy and understandability of the levels, such as including the behavior and medical support needs across all levels.

PIR resulted in some recommended changes to the support level descriptions based on feedback from the reviewers. The revised support level descriptions are in the Recommendations section of this report.

Findings on service mixes and budgets

We sought to explore three research questions related to service mixes and budgets:

1. Are service mixes and budgets generally adequate in each support level?
2. If any service mix or budget is not generally adequate, why?
3. What, if any, adjustments to the service mixes or budgets may be made that will better reflect potential service need?

Across all traditional service mixes reviewed, the service mixes and budgets are generally adequate in each support level. Regarding self-direction, the service mixes and budgets may be adequate for some but not all individuals.

Many individuals whose traditional service mix was identified as insufficient may qualify for a different level assignment if their SIS-A assessment was conducted more recently. In some circumstances, individuals may require more SLS support than provided in the service mix (e.g., 24-hour support in level 1 or 1:1 support 24/7 in levels M or B). SD CFH-like budgets were not completely adequate for most individuals, as most require and receive more hours of 1:1 support than the budget will afford. SD SLS-like budgets were insufficient for individuals who require 24-hour or close to 24-hour paid support. The Recommendations section of this report details our recommendations given that the SD budgets may not be adequate for all individuals who choose to self-direct.

Recommendations

Findings showed that the 5-level framework, level descriptions, and service mixes/budgets mostly work for individuals reviewed in the sample. As a result, HSRI does not have any recommendations regarding adjustments to the 5-level framework, level criteria, or individual service mixes. However, some outliers in support need, critiques of the level descriptions, and shortcomings in the self-directed service mixes/budgets point to recommendations for DHW to consider prior to implementing the new resource allocation model. This section identifies a series of recommendations based on PIR findings.

Clear SIS-A Reassessment Policy and Practice

Support level assignments can only be as accurate as the information which is used to determine them. For at least 9 of the 18 adults identified as outliers, the reason for the participant having much higher or much lower support need than others in the same level was seemingly a change in their support need since the time the SIS-A was conducted. Regular reassessment is fundamental to the new resource allocation model accurately reflecting the support need of participants. DHW has already identified a planned reassessment schedule once implementation begins with participants receiving a full SIS-A every three years and a focused review in the intervening years to identify whether the adult's support needs have changed sufficiently to require a full reassessment. HSRI recommends that DHW remain committed to that reassessment schedule and provide very clear guidance as to what qualifies during a focused review for a full reassessment to ensure changes in support

need which could impact support level assignment are not mistakenly overlooked. Further, HSRI recommends that DHW consider implementation of a policy that allows a participant to request a new SIS-A outside of their annual focused review in those instances where someone's support needs have changed so significantly as to make the previous SIS-A inaccurate. While the need to conduct such assessments may be rare, offering this opportunity when needed can help to ensure the new 5-level framework can work optimally to reflect the support needs of adults in the program.

Ongoing Quality Assurance of the SIS-A

While no specific concerns were raised during PIR regarding the quality of the SIS-A assessments reviewed, the importance of ongoing quality assurance processes cannot be overstated when the SIS-A is being used to assign support levels and budgets. In order for the new resource allocation model to be fairly applied, DHW must have complete confidence in the assessment used to assign those levels. The American Association on Intellectual and Developmental Disabilities (AAIDD), who developed the SIS-A, provides very specific guidance for ongoing training, the importance of conducting assessments on a regular basis, and completing quality assurance processes such as ongoing interrater reliability testing to support consistency across reviewers. HSRI recommends that DHW work closely with their IAP to ensure AAIDD recommended ongoing quality assurance processes are being adhered to.

Verification Process Support

During PIR there were multiple instances where a participant had support needs which appeared to possibly qualify them for inclusion in Level M or B. In some of these instances, the specific support need arose after the time the SIS-A was conducted, but in others it was not immediately clear to reviewers why the participant was assigned to another level. Verifications for the first cohort members occurred long before the implementation of the new resource allocation model was imminent. DHW detailed that, despite requests to participants who were flagged for Levels M and B to submit documentation to the verification team for review, very few participants did so, thereby making it difficult to verify that flagged participants met the criteria for these levels. Furthermore, a process for affirmatively requesting review by the Verification Team had not yet been established when these SIS-As occurred which may have reduced the number of participants thereby assigned to Levels M and B.

The verification process, while very similar to the current process for requesting Intense Supported Living, will be wholly new to participants who have selected other types of residential habilitation supports. The types of documents needed to confirm a participant meets the criteria for Levels M or B may not be familiar to or readily accessible by many participants and families. Levels M and B are intended for anyone who has the type of extraordinary support need indicated for that level, no matter the type of supports they choose to receive, it is therefore important that the verification process be understandable, accessible, and adequately supported.

HSRI recommends that DHW develop accessible materials outlining the verification process and provide additional explanation as to what types of supporting documentation can and should be submitted to the verification team to aid in the review process. Particularly during the implementation of the new resource allocation model, DHW, or their designee, should also identifying a specific individual tasked with answering questions and providing support to individuals and families engaging in this process or the first time.

Process for Addressing Self-Direction CFH-like Budget Concerns

As reported in the Findings section of this report, the service mix for self-direction CFH-like was identified as being inadequate for the majority of participants reviewed. It appears that historically participants who self-direct had access to, and utilized, a larger budget than this service mix provides. Reviewers identified that the traditional CFH service mix was adequate for 93% of those participants. The budget afforded within these two service mixes are more or less analogous. This suggests that the difference relates to how participants using traditional CFHs and how participants using self-directed CFHs were allowed to use their budgets.

The new resource allocation model is predicated on the idea that individuals with similar support needs and similar residential choices should have access to a similar amount of resources. It is for this reason that traditional and self-directed budgets, by participant-selected paid in-home habilitation support type, are more or less the same. Because the CFH service mix was found to be adequate for 93% of those participants reviewed it does not appear that the base CFH mix needs to be altered. As a result, HSRI does not recommend altering the self-directed CFH-like budget. However, the concerns raised about the adequacy of budgets for adults who self-direct must be addressed.

It appears that one cause of the seeming inadequacy of the self-direction CFH-like budget is the basis of 53.39 a day for CFH services. Participants who self-direct have not been limited to that amount; therefore, budgets based on that amount create a reduction. DHW has announced their intention to allow for increases to the payment for CFH services on the basis of health and safety as well as their intent to review the base rate paid to traditional CFH providers. While these adjustments may help to address concern in the long term, a number of adults who self-direct and receive CFH-like services will likely be concerned when receiving their new budgets.

HSRI recommends that, in addition to longer-term efforts to explore changes to the base CFH rate, DHW provide specific outreach to support brokers and participants who will receive the self-direction CFH-like service mix prior to implementation to specifically detail changes within the new resource allocation model, review those types of services that can be obtained outside of the budget, and outline the specific process for making a health and safety exceptions request.

Means for Obtaining 24 Hour 1:1 Support When Needed

PIR results suggest that for most adults in Levels M and B, 8 hours of shared support will adequately meet their needs. However, there do remain some adults whose medical and behavioral support needs are such that 1:1 staffing is required on a 24-hour basis. As currently devised, no service mixes or levels automatically account for 24 hours of 1:1 support. While this may be addressed through health safety exceptions for some, there are adults whose need for 24 hour 1:1 support does not derive from truly being unable to share support but from their inability to share a residence due to their behavior support needs.

In more than one circumstance, reviewers noted that a participant slept through the night without the need for eyes on support but needed to live alone due to behavioral concerns which became more acute when they had a roommate and which put the roommate at risk. While DHW does have an existing health and safety exceptions policy HSRI is not clear as to whether the need to live alone for health and safety would, in and of itself, qualify a participant for an exception to receive 24 hour 1:1 support if they could share staff during sleeping hours but for their needed living arrangement.

HSRI recommends that DHW clarify whether this need would qualify for a health and safety exception and if not determine other means to support participants to receive adequate 1:1 supports when more broadly necessary.

Update Level Descriptions to Align with PIR Feedback

While PIR reviewers did not identify any areas where the draft level descriptions mischaracterized the support need of adults in a given level, they provided valuable feedback regarding ways to expand and clarify the descriptions to better reflect the support needs of adults receiving DD services in Idaho. HSRI recommends amending the current draft descriptions as displayed in Figure 28. These revised descriptions can then be used in future communication with stakeholders regarding the 5-level framework to support greater broad understanding of the typical characteristics of participants at each support level.

Figure 28. Proposed Revised Level Descriptions

1	Adults in Level 1 have low support needs. They can manage many parts of their lives independently, or with little help and rarely, if ever, require 24 hours a day of support. Someone in this level may need support with tasks like clothing care, preparing meals, and housekeeping. They may require physical support for a few specific tasks but their support most often looks like monitoring or prompting. They may need help at times to participate in leisure activities, get and keep a job, or visit family and friends. Adults in this level may require support to manage behavioral concerns but these behaviors rarely, if ever, put them or others at imminent risk. Most often supports needed to address behaviors include coaching and redirection which are provided in the course of general daily supports. Adults in this level often require support such as facilitating doctor's appointments, preparing or administering medications, or supporting adherence to diets to promote health. Any more serious medical needs are typically well managed and managed within the course of general daily supports.
2	Adults in Level 2 have moderate support needs. Adults in this level often require support during much of their day but extensive dedicated support is not required. Most adults in the program have this level of support need. Adults in this level require varying amount of support depending on the specific task or situation. Considered across all areas of support, on average, adults in this level require supports that are beyond prompting but not complete physical support. However, some adults in this level do require partial physical support in the majority of areas. An adult in Level 2 could need no support for eating meals or getting dressed, monitoring or prompting for personal hygiene, partial physical assistance for housekeeping and communicating with others, and full physical assistance for meal preparation and transportation. The combination of supports needed by adults in this level will vary person to person. Adults in this level have a range of behavior support needs. They may exhibit anywhere from no behaviors to behaviors that could result in harm to themselves or others. The support needed to address these behaviors also range from minimal coaching and redirection to frequent focused support and periodic physical intervention. However, adults at this level do not require one-to-one support to address their needs related to behavior. Adults in this level often require support such as facilitating doctor's appointments, preparing or administering medications, or supporting adherence to diets to promote health. Most serious medical needs are well managed;

	however, some adults have medical support needs that require dedicated attention (e.g., daily diabetes management).
3	Adults in Level 3 have high to very high support needs. Adults in this level often require support during much of their day and require some physical supports in most areas. However, supports may be limited to prompting or supervision in some areas. Adults in this level have at least some support needs which require 1-to-1 support on a regular, but not constant, basis. An adult in this level could need daily physical help to prepare food, get dressed, bathe, complete household chores, and maintain physical safety while requiring only prompting and supervision to eat foods that have been prepared or communicate their wants and needs with others. An adult in this level may also likely need partial-to-full physical help to get and keep a job, access the community, and take part in preferred community activities. Adults in this level require behavioral support ranging from low (e.g., coaching, supervision in some environments) to high (e.g., supervision in most environments and occasional physical intervention). Adults in this level may also have medical support needs, though these medical needs most often do not require dedicated attention outside of daily supports. They may need physical support for facilitating doctor's appointments, preparing or administering medications, or supporting adherence to diets to promote health. Most serious medical needs are well managed. However, some adults in this level have medical support needs that require dedicated attention.
M	Adults in Level M have an extraordinary need for medical support. Because of their significant medical support need most, but not all, adults in this level require physical support for most daily activities. Adults in this level have a range of behavior support needs but the amount of support they need is primarily related to their medical conditions. In this level, an adult has a medical condition or conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and frequent monitoring.

B	Adults in Level B have extraordinary behavioral challenges. The supports adults require for medical conditions or to complete general daily activities varies widely in this level. However, behavior support needs are such that the adult requires 1-on-1 support for most, and in some cases all, hours of the day. In order to be assigned to this level, an adult must require intense 24-hour support and supervision due to one of the following: a recent felony conviction or charges for offenses related to the serious injury or harm of another person, a documented history of predatory sexual offenses with a high risk to re-offend whether or not they have been involved with the criminal justice system, a documented or sustained history of serious, aggressive behavior which requires continuous monitoring to prevent potential injury to themselves or others.

Clear Health and Safety Exceptions Policies and Procedures

Service mixes and budgets within the new resource allocation model only apply to a specific sub-set of available services. Access to other necessary services (e.g., home-delivered meals, PERs) rely solely on a well-orchestrated health and safety exceptions process. Health and Safety Exceptions are also tasked with providing access to 24-hour 1:1 support to those participants who require it, authorizing additional support by CFH providers when justified, and managing any number of other requests that will likely occur as the program moves into the new resource allocation model.

This all puts a great deal of pressure on the exception process and increases the importance of having a set of clearly defined policies and procedures around exceptions. Exceptions processes can often be lengthy, with ill-defined timelines and a lack of clarity regarding where in the process a particular request sits. HSRI recommends that prior to implementation of the new resource allocation model DHW focus significant efforts on developing a set of specific policies and procedures for health and safety exceptions, delineating those types of requests that are anticipated, streamlining processes where possible, and detailing specific and achievable timelines for when request will be processed. Such efforts, along with allocating adequate resources to process the likely increase in exceptions requests as implementation begins, will help show DHW's commitment to addressing the needs of participants.

Ongoing Evaluation

PIR offers insight into how the resource allocation model is working prior to implementation and can provide guidance on how it can be adjusted and improved prior to rollout. However, the best way to gauge how the model is working is to conduct ongoing evaluation once implementation has begun. The new resource

allocation model is built to promote and support adjustments and updates as needed but only through ongoing review will the need for such updates come to light. Various stakeholders and DHW have already identified areas where additional work is needed to address broader concerns in the supports being offered. While HSRI is aware that ongoing evaluation is already planned we note the importance of this process to build upon the information gathered as part of PIR and support ongoing growth and improvement to the new resource allocation model.

Appendix

Revised Draft Service Mixes (as of PIR)

State Plan HCBS Only Service Mix					
Supports Level	1	2	3	M	B
Developmental Therapy/Center	4	4	5	3	3
Developmental Therapy/Community	4	5	6	3	3
Community Habilitation Individual	5	5	6	10	10
Community Habilitation Group	5	6	5	6	6
Total Hours Per Week:	18	20	22	22	22
Non-medical Transportation	2000 miles	2000 miles	2000 miles	2000 miles	2000 miles
Service Coordination/Planning	$3,192	$3,192	$3,192	$3,192	$3,192
Total Budget Range Per Year:	$17,846 to $21,466	$19,182 to $22,736	$20,848 to $25,210	$22,552 to $29,816	$22,552 to $29,816

No Paid Residential Habilitation Supports Service Mix					
Supports Level	1	2	3	M	B
Adult Day Health	4	4	5	0	0
Developmental Therapy/Center	5	5	5	0	0
Developmental Therapy/Community	5	5	5	0	0
Prevocational Individual	0	0	1	2	2
Prevocational Group	0	0	1	0	0
Career Planning	1	1	1	2	2
Community Habilitation Individual	3	4	6	17	17
Community Habilitation Group	5	7	5	0	0
Total Hours Per Week:	23	26	29	21	21
Non-medical Transportation	3600 miles	3600 miles	3600 miles	3600 miles	3600 miles
Service Coordination/Planning	$3,192	$3,192	$3,192	$3,192	$3,192
Total Budget Range Per Year:	$19,966 to $23,800	$22,364 to $26,808	$24,852 to $32,920	$27,030 to $46,100	$27,030 to $46,100

Certified Family Home Service Mix					
Supports Level	1	2	3	M	B
Residential Supports: CFH	365 days	365 days	365 days	365 days	365 days
Adult Day Health	4	4	5	0	0
Developmental Therapy/Center	5	5	5	0	0
Developmental Therapy/Community	5	5	5	0	0
Prevocational Individual	0	0	1	2	2
Prevocational Group	0	0	1	0	0
Career Planning	1	1	1	2	2
Community Habilitation Individual	3	4	6	17	17
Community Habilitation Group	5	7	5	0	0
Total Hours Per Week:	23	26	29	21	21
Non-medical Transportation	3600 miles	3600 miles	3600 miles	3600 miles	3600 miles
Service Coordination/Planning	$3,192	$3,192	$3,192	$3,192	$3,192
Total Budget Range Per Year:	$39,453 to $43,287	$41,851 to $46,295	$44,339 to $52,407	$46,517 to $65,587	$46,517 to $65,587

Supported Living Service Mix					
Supports Level	1	2	3	M	B
Residential Supports: SLS	365 days 14 hours/day (group)	365 days 18 hours/day (group)	365 days 12 hours/day (group) 6 hours/day (individual)	365 days 8 hours/day (group) 16 hours/day (individual)	365 days 8 hours/day (group) 16 hours/day (individual)
Adult Day Health	4	7	8	0	0
Developmental Therapy/Center	5	6	6	0	0
Developmental Therapy/Community	5	7	6	0	0
Prevocational Individual	0	1	1	1	1
Prevocational Group	0	0	0	0	0
Career Planning	1	1	0	1	1
Community Habilitation Individual	3	5	7	7	7
Community Habilitation Group	5	6	5	0	0
Total Hours Per Week:	23	33	33	9	9
Non-medical Transportation	2000 miles	2000 miles	2000 miles	2000 miles	2000 miles
Service Coordination/Planning	$3,192	$3,192	$3,192	$3,192	$3,192
Total Budget Range Per Year:	$55,696 to $69,763	$72,788 to $92,757	$104,056 to $133,004	$169,767 to $222,889	$169,767 to $222,889

Self-directed Service Mixes

	1	2	3	M	B
Self-Directed community support services similar to Certified Family Home	$40,749 to $44,583	$43,147 to $47,591	$45,635 to $53,703	$47,813 to $66,683	$47,813 to $66,683
Self-Directed community support services similar to Supported Living	$53,456 to $66,511	$69,536 to $88,206	$97,774 to $124,554	$155,909 to $204,680	$155,909 to $204,680
Self-Directed with no residential habilitation community support services	$21,262 to $25,096	$23,660 to $28,104	$26,148 to $34,216	$28,326 to $47,396	$28,326 to $47,396