Georgia Department of Behavioral Health & Developmental Disabilities
Judy Fitzgerald, Commissioner

Facts about the COMP Waiver Renewal Implementation For Families and Individuals Who Self-Direct Services

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On February 23, 2017, the Centers for Medicare and Medicaid Services (CMS) approved renewal of the Comprehensive Supports Waiver Program (COMP) through March 31, 2021. The renewal reflects collaborative work by the Georgia Departments of Behavioral Health and Developmental Disabilities (DBHDD) and Community Health (DCH) over a two-year period involving in-depth review of services requirements, a study of service rates, and information gathered from providers, family members, and waiver participants about services.

The frequently asked questions and answers below are designed to assist family members who self-direct services in understanding specific elements of the COMP Waiver renewal implementation. A series of forums were held in March 2017 to inform providers and families of the changes and respond to direct questions and concerns. A session recorded for family members during the development of the renewal application, as well as other information about the rates and service changes, is available at: http://dbhdd.georgia.gov/developmental-disabilities.

Summary of Changes to the COMP Waiver Program

What are the primary changes approved by CMS with the COMP Waiver renewal?

- Incorporates new provider payment rates based on a cost study conducted by DBHDD. Because increased service rates resulted in higher overall cost of certain services, annual maximum "caps" were increased to reflect the rate increases.
    - The annual maximum cost cap was increased for community living support services and respite services.

- Establishes rate categories for certain services based on waiver participant's assessed level of need. The only service affected by level-of-need categories in the participant-direction model is respite.

- Increases the cost cap on physical, occupational, and speech therapies from a total therapy cap of $1,800 to a maximum cost of $5,400 annually, based on assessed need.

- Adds nutrition services to the list of services available through the waiver. Nutrition services are designed to offer the professional services of a registered dietician for waiver participants with complex conditions and diagnoses that

affect nutritional status. Nutrition services are not available under the participant direction service delivery model.

- Increases the cost cap for Specialized Medicaid Supplies for adults from $1,868 to $3,800 with the authorized amount determined through needs assessment.

Description of COMP Waiver Changes by Service Type

How do COMP waiver changes affect participant-direct community living support services (CLS)?

- CLS services have been changed to reflect many more options for families and individuals.

- The annual maximum allowance for individual CLS has been increased by 7.2% which will be applied to the individual allocations for CLS across the board for all waiver participants who self-direct CLS.

- Daily rates have been eliminated and will be replaced by hourly rates for participant-directed CLS.

- Feedback from many parents during the public forums led DBHDD staff to understand the desire of parents and individuals to use a supported living model to allow maximum independence in a "roommate arrangement."

- Using this feedback, DBHDD established 'multi-person' rates for individuals who choose to live together and share supports in groups of two or three. This service creates an opportunity to receive more hours since the sharing of one direct support staff between two or three individuals results in the ability to 'stretch' services.

- Shared CLS services can be used for sibling pairs whose needs can be met through sharing one direct support staff person. Families with siblings or other natural pairs may use one staff for part of the day (two-person shared), and one-to-one CLS staffing for other times of the day when each sibling requires focused attention.

The new rates designed for traditional agencies are found in the table below. These rates can be used as guidelines for establishing hourly rates for participant-directed staff. Traditional services are reimbursed by the 15-minute unit but hourly rates have been included in the table for comparison with hourly rates.

The rate table for traditional respite service reimbursement is included below to serve as a guide for families wishing to adjust staff pay rates.

Note: the rates below reflect all administrative costs including payroll taxes for employees. If using these rates as a guide, please allow adjustment for taxes.

CLS Service	Unit	Rate	Notes
Basic CLS (1 person)	15-minute/ hour	$6.35/ $25.40	Basic service = 2.75 hours per visit
Extended CLS (1 person)	15-minute/ hour	$5.74/ $22.96	Extended service = 3 hours or more / visit
2 Members - Basic	15-minute/ hour	$3.49/ $13.96	• Allows waiver participants to share one direct support staff member • Designed for voluntary staff sharing to allow purchase of more hours • Clinical need, different needs, or significant difference in assessment levels may require continuation of individual model, even if participants live in the same home
2 Members - Extended	15-minute/ hour	$3.16/ $12.64	
3 Members - Basic	15-minute /hour	$2.54/ $10.16	
3 Members - Extended	15-minute/ hour	$2.30/ $9.20	

- Basic CLS represents reimbursement for short visits while extended CLS describes services delivered in visits lasting three hours or longer. The slightly higher reimbursement rate for basic services reflects fixed travel costs that are not dependent on the length of visit, as well as time lost in travel since Medicaid does not reimburse travel time to and from the work setting.

What do I need to do about moving from a daily code and rate to an hourly rate?

- The rate sheets used to direct fiscal support service agencies on how to reimburse your staff will need to be resubmitted using an hourly rate.

- If you would like to use a shared model of CLS, indicate the hourly rate to be used for two-person CLS and/or three-person CLS. It is recommended that you use the rate table above to guide your decisions. Though participant-direction allows you flexibility in the rate you reimburse your staff, the hourly rate should be reasonably close to the traditional provider rate. Funding will not be increased to accommodate gross overpayment of staff.

- If you already use an hourly rate to reimburse CLS staff, you do not need to do anything. *If you were using a daily reimbursement rate, you will need to calculate an hourly rate in order to continue billing for CLS after July 1, 2017. Your new rate must be communicated to your selected fiscal intermediary prior to July 1, 2017.*

Respite Services

How are respite services changing?

- The rates for respite services have increased. This increase was designed to improve access to respite services. Respite will continue to be offered in both an hourly model as well as a daily or "overnight" rate. Respite services can accommodate individuals with a higher level of need by authorizing a higher maximum funding cap, thus allowing higher pay rates for staff with special skills and expertise.

What is the new limit on respite services?

- The annual respite limits are being increased to $4,608 minimum and slightly more if the individual's support needs are high as determined through assessment. The Supports Intensity Scale (SIS) assessment, the SIS Supplemental questions, and the Health Risk Screening Tool (HRST) are administered and/or validated by DBHDD to determine support needs. The new limits are based on 30 days of the daily/overnight respite rate.

The rate table for traditional respite service reimbursement is included below to serve as a guide for families wishing to adjust staff pay rates. *Note: the rates below reflect all administrative costs including payroll taxes for employees. If using these rates as a guide, please allow adjustment for taxes.*

Service	Unit	Rate	Notes
Respite-15-Minutes 1 Waiver Participant	15-min / hr	$4.83 /$19.32	• Shorter units were designed to accommodate a short respite "visit" and may be delivered in the family home or in an out-of-home setting for up to 7.5 hours/day. • Allows sharing of in-home respite for maximum hours • Can be used for siblings living together or by individuals living with family who are compatible and choose to share services
Respite-15-Minutes 2 Waiver Participants	15-min / hr	$2.66 /$10.64	
Respite-15-Minutes 3 Waiver Participants	15-min / hr	$1.93 /$7.72	
Respite-Daily (Overnight) Category 1	One day	$153.61	• Daily respite was designed to accommodate the need for overnight or full day service of 8 hours or more per "visit." Can be delivered in the family home or an out-of-home setting such as a host home or licensed community living arrangement or licensed personal care home.
Respite-Daily (Overnight) Category 2	One day	$209.51	

			• Respite categories are determined by level of need through use of information discovered through the SIS and Health Risk Screening Tool. These assessments are administered for all waiver participants but must be current.

- Annual limit is as authorized in the individual budget up to the annual maximum of:
  - $4,608 for Category 1 Respite
  - $6,285 for Category 2 Respite

- Annual limit can be used for hourly respite, daily/overnight respite, or a combination. Your family may be best served by having a combination of respite options to include both in-home and "daily" respite. Daily respite can be provided either during the day or overnight.

- It is recommended that you use the rate table above to guide your decisions. Though participant-direction allows you flexibility in the rate you reimburse your staff, the hourly rate should be reasonably close to the traditional provider rate. Funding will not be increased to accommodate gross overpayment of staff.

What do I need to do?

- If your family would like to use the *shared respite model*, you will need to submit a new rate sheet. The rate sheet must be revised to reflect your proposed use of two-person or three-person shared services.

- If your family would like to use the *daily respite model*, you may need to submit a new rate sheet if you plan to increase the pay rate to your staff based on the new allowable amount.

- Note: If you think you might use multiple types of respite services, you can submit rate sheets for each, e.g. shared two-person, one-to-one hourly rate, and daily respite for overnights.

General Questions

When and how can I request changes to my family member's individualized service plan (ISP) based on the new allowable maximum amounts for services?

- Generally, you will wait until the next ISP meeting to request changes, but if you have a current assessed need for additional services, you may request an increased service through your support coordinator.

- If the need has not been identified through standard assessment by DBHDD field staff, the request for increase may require a new assessment: Health Risk Screening Tool (HRST), Supports Intensity Scale (SIS), nursing evaluation, behavioral evaluation, or social work evaluation.

- If the need has been established, for example, the need for specialized medical supplies, but you have been paying out of pocket for needed supplies because of the cost cap on that service, you may request an increase in the allocation based on established need. Your support coordinator will submit a service change/technical assistance request to the regional field office for review as a "change in circumstance."

- If requesting nutrition services, please note that a clinical assessment will need to be performed since this service requires a physician order and must be delivered by a registered dietitian. A traditional provider of services will need to be selected if you wish to use nutrition services.

What if I have more questions that are not answered in this fact sheet?

- It is always a good idea to first contact your support coordinator, but since this COMP Waiver Renewal includes several changes that may not be fully understood, please feel free to seek information and clarification from DBHDD by sending a message to COMP.ImplementationQuestions@dbhdd.ga.gov. Your support coordinator will be copied on the response message to ensure that both of you receive the same guidance.

- Additionally, a is webinar scheduled for May 22, 2017, from 10:30 a.m. to 12:30 p.m. to discuss the information included in this fact sheet and to answer questions related to the COMP Waiver renewal implementation as it relates to the participant-directed service delivery model.

- Specific information, including a registration link for the webinar, is available at: www.dbhdd.georgia.gov/developmental-disabilities-training-announcements-0.