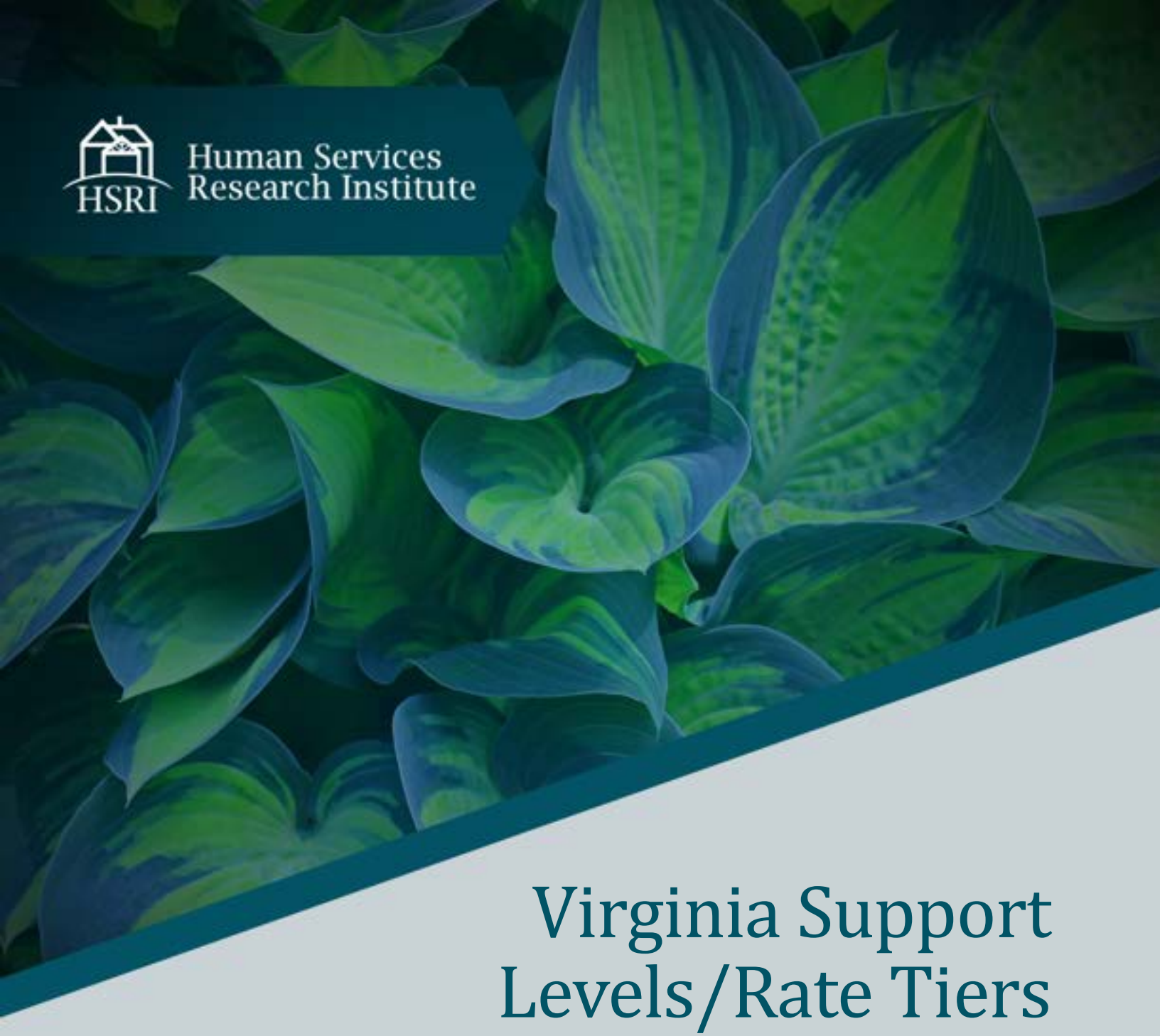

Human Services Research Institute

HSRI

Virginia Support Levels/Rate Tiers Updates Report

August 31, 2024

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The recommendations and considerations in this report are from the authors and do not necessarily reflect the views of Department of Behavioral Health and Developmental Services.

Contents

Plain Language Summary

In 2013, Human Services Research Institute (HSRI) and our partners with Health Management Associates (HMA-Burns), worked with Virginia Department of Behavioral Health and Developmental Services (DBHDS). We developed support levels and rate tiers. A support level shows the amount of help that someone needs. A rate tier is how much DBHDS pays for services for each support level. The support levels are based on the Supports Intensity Scale® (SIS®), supplemental questions, and a document review for some people. These support levels are used today.

In 2020, the SIS-A® changed. Some of the changes are:

- Different questions about the person
- New medical questions
- A new behavioral question
- Scoring

These changes are important to make sure the assessment is still a good assessment. These changes are called the SIS-A® 2nd Edition. Because of these changes, DBHDS *must* update the support levels.

Over the last year, HSRI and our partners at HMA-Burns, DBHDS, Department of Medical Assistance Services (DMAS), and a project advisory group, researched these changes. Based on this research, support levels should be updated.

How should support levels be updated?

We analyzed the support levels. Analysis shows that there should be six support levels. There are seven today. Analysis also shows that we should use the entire SIS-A 2nd Edition to decide on the support levels. There should be 4 support levels for people with low to very high general supports needs. General support needs are the help people need with their daily life. General support needs include help for eating, bathing, dressing, getting out in the community, and other things people need help with every day. There should also be a support level for people with extensive medical needs and a support level for people with extensive behavioral needs. The updated support levels and rate tiers are shown in the chart "Proposed Support Levels and Rate Tiers."

*Figure 1. Proposed Support Levels and Rate Tiers**

Rate Tier	Current Support Level	Proposed Support Level	Support Level Descriptions
1	1	1	Low general support need, no exceptional medical or behavioral needs
2	2	2	Moderate general support need, no exceptional medical or behavioral needs
3	4	3	High general support need, no exceptional medical or behavioral needs
4	5	4	Very high general support need, no exceptional medical or behavioral needs
4	6	M	Exceptional medical support need, no exceptional behavioral needs
4	7	B	Exceptional behavioral support need

*Previous Support Level 3 is not shown. The remainder of the support levels are comparable.

Our analysis also shows that the SIS-A 2nd Edition scores that get people into each support level should also change.

Should the rate tiers be updated?

The rate tiers do not need to be updated. The support levels are comparable to today. That means that they are similar. For example, the current Support Level 4 is for people who have high general support needs. The updated Support Level 3 is also for people who have high general support needs. Support levels that are comparable to the support levels today will still match to the same rate tiers. For example, Support Level 6 today is for people with extensive medical support need and gets a rate tier of 4. The medical support level, Support Level M, that we propose, also matches to rate tier 4. We show the match of the support levels to rate tiers above.

How will these updates affect people receiving services?

If DBHDS decides to update the support levels, people won't receive a new support level until they take a SIS-A® 2nd Edition. When people take a SIS-A® 2nd Edition, we think most people will get a similar support level as today. Our analysis shows that about 3 of every 4 people will get a similar support level. Some people may get a higher support level. Our analysis shows that about 18% of people would get a higher support level. That means that if their support level is a 2 today, after they take their SIS-A® 2nd Edition it may be a 3. About 6% of people would get a lower level. That means that if their support level is a 3 today, after they take their SIS-A® 2nd Edition it may be a 2.

Our analysis shows that most providers delivering tiered services will be paid more. This is because we expect that more people will get higher levels. How much providers get paid depends on people they serve.

Our analysis shows that it will cost DBHDS about $34.3 million to update the support levels. This cost will be spread over four years as people begin taking the SIS-A 2nd Edition.

When will DBHDS start using the SIS-A 2nd Edition?

DBHDS plans to begin using the SIS-A 2nd Edition on October 1, 2024. DBHDS will need to complete work to prepare for using the SIS-A 2nd Edition. DBHDS will need to share information about these changes with everyone to make sure that people are ready to begin using the SIS-A 2nd Edition. DBHDS also needs to make sure people understand the changes.

Proposed Updates

In 2013, Human Services Research Institute (HSRI) and our partners, Burns & Associates (now a division of Health Management Associates, HMA-Burns), were contracted by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to develop support levels and rate tiers for people using waiver services on all Virginia's three Medicaid Section 1915 waivers for people with developmental disabilities (DD). These waivers are now titled the Building Independence waiver, the Community Living waiver, and the Family and Individual Support waiver. At that time, we developed a model that relies on results from the Supports Intensity Scale® (SIS®), supplemental questions, and a document review verification process (for some people) to assign each person to a support level. For services with tiered rates, support levels are used to determine the rate tier.

In 2020, the developer of the SIS—the American Association on Intellectual and Developmental Disabilities (AAIDD)—released the Supports Intensity Scale-Adult Version (SIS-A) 2nd Edition. Changes include:

- Changes to the demographic section
- Addition of 6 new medical questions and adjustments to existing medical questions, and the removal of 1 question

- Addition of 1 new behavioral question
- Changes to the norming of the support needs scales (that is, revising the conversion of raw scores to standard scores)
- Some sections and subsections have been renamed
- Some questions have been reworded and reordered for clarity
- Adding the Advocacy Activities Scale to the Support Needs Index (SNI)

AAIDD made these changes so that the SIS-A 2nd Edition still validly measures support needs. It is essential to use a support needs assessment that responds to changes over time[1]. These changes allowed AAIDD to make sure that scores meaningfully compare to the support needs of people using the assessment today, rather than relying on the testing from 20 years ago. The SIS-A 2nd Edition was updated using over 160,000 assessments of culturally diverse people with intellectual and developmental disabilities in a multiyear project that ended in 2022[2]. Changes are documented in a memo[3] on AAIDD's website as well as a frequently asked questions document[4] and a plain text summary[5]. As a result of these changes, DBHDS determined a need to update the support levels and rate tiers. DBHDS is planning to begin using the SIS-A 2nd Edition in October 2024.

Through 2023 and 2024, HSRI and our partners at HMA-Burns, with the support DBHDS, the Department of Medical Assistance Services (DMAS), and a project advisory group, researched and analyzed the impact of these changes. In this paper, we provide information about proposed changes resulting from this project, policy and practice needs, background and methods, a transition plan, and a communication plan. In this section, we provide proposed updates to the support level/rate tier model. More information about our project can be found in Background and Methods.

Use of the Supports Intensity Scale

Early in this project, DBHDS identified that it was going to continue to use the SIS as its comprehensive assessment and to assign support levels that determine rate tiers. Continuing to use the SIS assessment has many benefits for DBHDS, people receiving services, and providers. Since the SIS has been in place for more than a decade, most people receiving services and their families, as we as numerous providers and support coordinators, have participated in a SIS assessment, gaining familiarity with the process and the assessment. Hearing concerns from the community,

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[1] Verdugo, M. A., Aguayo, V., Arias, V. B., & García-Domínguez, L. (2020). A systematic review of the assessment of support needs in people with intellectual and developmental disabilities. International Journal of Environmental Research and Public Health, 17(24), 1–26. https://doi.org/10.3390/ijerph17249494

[2] https://www.aaidd.org/docs/default-source/sis-docs/sis-faqs.pdf?sfvrsn=9eda3f21_8

[3] https://www.aaidd.org/docs/default-source/sis-docs/sis-memo.pdf?sfvrsn=da3f21_6

[4] https://www.aaidd.org/docs/default-source/sis-docs/sis-faqs.pdf?sfvrsn=9eda3f21_8

[5] https://www.aaidd.org/docs/default-source/sis-docs/sis-memo-plaintext.pdf?sfvrsn=82da3f21_6

DBHDS put several processes in place, such as SIS Standard Operating Procedures (SOP)[6] and a SIS reassessment request[7] process, to help mitigate these concerns. The information generated in the SIS assessment can be used for planning purposes and can spur conversations about different life domains that may not have been previously addressed, such as lifelong learning and employment. This can help people receiving services, and their planning team, to better define what support they need to be successful in different areas of their lives. For providers, the SIS assessment, support levels, and rate tiers allow for a tiered rate schedule that aligns payments with the greater costs of supporting people with greater needs, particularly related to staffing ratios. Providers can also use the information generated in the SIS assessment to inform the supports needed for successful service delivery.

DBHDS is invested in the SIS assessment, in part, because of its strong psychometric properties, including validity and reliability[8], that ensure consistent and accurate results. Validity means the assessment measures what it purports to measure—in this case support needs. Reliability means the assessment measures consistently. Strong psychometric properties are present even at the extreme ends of need, as shown in a study by Wehmeyer et al.[9] that focused on people with extensive support needs. The SIS also has documented validity for people with autism[10].

Federal regulations require that person-centered plans must meet the clinical and support needs identified through a functional needs assessment (42 CFR § 441.301). DBHDS uses the Virginia Individual Developmental Disability Eligibility Survey (VIDES)[11] as its functional needs assessment. DBHDS also uses the SIS every three or four years depending on the age of the person in conjunction with the supplemental questions, as appropriate, and other assessment information to develop each individual's person-centered plan . DBHDS has developed significant infrastructure to administer and use the SIS. The vendors that conduct SIS assessments receive training and are routinely tested for inter-rater reliability to ensure they complete the assessment accurately and consistently. Interviewers are supported and endorsed by AAIDD.

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[6] https://dbhds.virginia.gov/wp-content/uploads/2023/05/DBHDS-SIS%C2%AE-Standard-Operating-Procedures-and-Review-Process-4.28.2023.pdf
[7] https://dbhds.virginia.gov/assets/Developmental-Services/waiver/rsu/SIS-Reassessment-Request-Instructions-6.15.17.pdf
[8] Thompson, J. R., Schalock, R. L., & Tassé, M. J. (2018). Evidence for the reliability and validity of the Supports Intensity Scales. [White paper]. www.aaidd.org
[9] Wehmeyer, M., Chapman, T. E., Little, T. D., Thompson, J. R., Schalock, R., & Tassé, M. J. (2009). Efficacy of the Supports Intensity Scale (SIS) to predict extraordinary support needs. American Journal on Intellectual and Developmental Disabilities, 114(1), 3–14. https://doi.org/10.1352/2009.114:3-14
[10] Thomson, J.R., Anderson, M.H., & Shogren, K.A. (2021). Measuring the support needs of people with intellectual disability and autism spectrum disorder. Education and Training in Autism and Developmental Disabilities, 56(1), 18-26.
[11] https://dbhds.virginia.gov/assets/doc/DS/rsu/VIDES-Adult-Instr-Clarification-v-12-21-2018.pdf

For services with acuity-based ("tiered") rates, DBHDS uses the SIS to determine the tier to which a person will be assigned. The SIS can be effectively used to support tiered rates because it was developed for the expressed purpose of measuring support needs—which drive the staffing intensity that a person requires—rather than diagnosing disabilities or assessing risk. DBHDS uses SISOnline[12] to collect SIS data. This allows DBHDS to easily collect comprehensive and accurate data on each person who participates in the SIS assessment, which is important for applying the results of the assessment across the whole population. Finally, the SIS has been translated into numerous languages, making it a good fit for diverse populations These translations are documented in peer reviewed journals[13].

In a review of 86 articles and nine different assessments[14], researchers determined that measuring support needs is a better predictor of financial need than other types of assessments (e.g., adaptive behavior scales, type of care, competence measures, etc.). In fact, many studies have stated that the SIS is appropriate for funding decisions[15]. When funding is assigned based on the person's support needs, it reduces outside factors (e.g., system factors, historical differences, etc.) from influencing a person's level of funding[16].

A support needs assessment should capture an person's medical, behavioral, and day-to-day needs[17], which the SIS does. The SIS is strengths-based and does not rely on diagnosis to determine need. The SIS is a direct measure of support needs, which is necessary when tying support needs to

[12] https://www.aaidd.org/sis/sisonline
[13] Schalock, R. L., Thompson, J. R., Tassé, M. J., Buntinx, W., Croce, L., Ekstein, Y., Giné, C., Holmes, S., Lamoureux-Hébert, M., Leoni, M., Morin, D., & Verdugo, M. A. (2008). International implementation of the Supports Intensity Scale TM. www.aaidd.org
[14] Verdugo, M. A., Aguayo, V., Arias, V. B., & García-Domínguez, L. (2020). A systematic review of the assessment of support needs in people with intellectual and developmental disabilities. International Journal of Environmental Research and Public Health, 17(24), 1–26. https://doi.org/10.3390/ijerph17249494
[15] Dizdarevic, A., Ahmetovic, Z., Malec, D., Mujezinovic, A., Ahmetovic, M., Zilic, F., & Mehmedinovic, S. (2020). Analysis of factor validity of the Support Intensity Scale on Bosnian-Herzegovinian sample. Advances in Cognitive Psychology, 16(2), 117–130. https://doi.org/10.5709/acp-0290-x
[16] Schalock, R. L., Thompson, J. R., Tassé, M. J., Fortune, J., Levelle, J. A., Meche, S., Severance, D., Smith, G., Stern, J., van Loon, J., Weber, L., & Campbell, E. M. (2008). Resource allocation and the Supports Intensity ScaleTM: Four papers on issues and approaches. [White paper]. www.aaidd.org
[17] Verdugo, M. A., Aguayo, V., Arias, V. B., & García-Domínguez, L. (2020). A systematic review of the assessment of support needs in people with intellectual and developmental disabilities. International Journal of Environmental Research and Public Health, 17(24), 1–26. https://doi.org/10.3390/ijerph17249494

funding[18]. Finally, the SIS can be used virtually, with a nominal impact on support need scores[19]. This allows for flexibility, allowing DBHDS to adapt each person's needs.

For these reasons, DBHDS intends to continue using the SIS as a comprehensive assessment for planning and for continued use of tiered rates. With the forthcoming changes in the SIS-A 2nd Edition, DBHDS recognized the need to update the support levels and rate tiers. Based on the results of our project, we propose several changes to the support level/rate tier model to accommodate the updates to the SIS-A 2nd Edition.

Support Levels

For services with tiered rates, a person's assigned support level is used to determine their rate tier. As a result of our analysis, we are proposing changes to the support levels, which are shown in the figure below.

Figure 2. Proposed Support Levels

1	Low general support need, no exceptional medical or behavioral needs
2	Moderate general support need, no exceptional medical or behavioral needs
3	High general support need, no exceptional medical or behavioral needs
4	Very high general support need, no exceptional medical or behavioral needs
M	Exceptional medical support need, no exceptional behavioral needs
B	Exceptional behavioral support need

[18] Brown, H. K., Ouellette-Kuntz, H., Bielska, I., & Elliott, D. (2009). Choosing a measure of support need: Implications for research and policy. Journal of Intellectual Disability Research, 53(11), 949–954. https://doi.org/10.1111/j.1365-2788.2009.01216.x

[19] Carlson, S. R., Thompson, J. R., & Shaw, L. (2023). The impact of administration formats on SIS-A® scores. American Journal on Intellectual and Developmental Disabilities, 128(1), 66–81. https://doi.org/10.1352/1944-7558-128.1.66

While the proposed support levels are similar to the current support levels, there are several important changes. For example, current support levels consider only certain subsections of the SIS-A:

- 1A: Exceptional Medical Support Needs
- 1B: Exceptional Behavioral Needs
- 2A: Home Living Activities
- 2B: Community Living Activities
- 2E: Health and Safety Activities (this has been reordered to Section 2C in the SIS-A 2nd Edition)

Going forward, we propose that the support levels consider all sections of the SIS-A 2nd Edition:

- 1A: Exceptional Medical Support Needs
- 1B: Exceptional Behavioral Needs
- 2A: Home Living Activities
- 2B: Community Living Activities
- 2C: Health and Safety Activities
- 2D: Lifelong Learning Activities
- 2E: Employment Activities
- 2F: Social Activities
- 2G: Protection and Advocacy Activities

The general support needs levels (Support Levels 1 through 4 in Table 4 above) would use the SNI score, which is the overall (composite) score of subscales 2A through 2G.

As exists today, we propose four support levels for people with increasing general support needs (Support Levels 1-4). We also propose to maintain support levels for people with exceptional medical and behavioral support needs (Support Levels M and B), consistent with Support Levels 6 and 7 today.

We also propose to eliminate the current Support Level 3, which was established for people with low-to-moderate general support needs and elevated, but not exceptional behavioral support needs. With other proposed changes to the support level framework, many people who were assigned to support level 3 will be assigned to a different, higher support level. Further our statistical analysis did not provide support for this type of support level. In the proposed Support Level framework, Support Level 3 is generally equivalent to the current Support Level 4.

The composition of the support levels—the people who are assigned to each support level—will change somewhat, but a large majority of people will remain in a comparable support level. Of the people who will change support levels, significantly more will move to a higher support level than to a lower level. The figure below details the criteria for the proposed support levels.

Figure 3. Proposed Support Level Criteria

Support Level	SNI	Medical Support (Section 1A)	Behavioral Support (Section 1B)
1	Up to 86	Less than 9	Less than 11
2	87-101	Less than 9	Less than 11
3	102-115	Less than 9	Less than 11
4	116 and up	Less than 9	Less than 11
M	Any	9 and up OR Verified medical need	Less than 11
B	Any	Any	11 and up OR Verified behavioral need

In addition to the proposed changes to the SIS-A 2nd Edition assessment scores used to assign people to support Levels, we recommend changes to the supplemental questions and criteria for flagging for document review verification.

The supplemental questions ask about medical and behavioral needs to identify people who may need additional supports that are not captured in the SIS-A. Certain responses to these supplemental questions flag a person for document review verification to confirm the presence of these additional needs. This document review verification may result in people being assigned to the support levels for people with exceptional medical or behavioral support needs.

We propose changes to the supplemental questions to ease their administration, update language, and align better with the information that document review verification seeks to confirm. In the figure below, we outline the proposed changes to supplemental questions and the flagging criteria. Along with changes to the flagging criteria, we recommend that the medical supplemental question be asked of anyone who has a score of 2—a rating of exceptional support needed—on any item in Section 1A of the SIS-A 2nd Edition and the behavioral supplemental question be asked of anyone who has a score of 2—a rating of exceptional support needed—on any item in Section 1B. This is consistent with practice today and helps ensure the supplemental questions are asked of anyone who may have exceptional needs. The proposed supplemental questions are shown in the figure below.

Figure 4. *Proposed Supplemental Questions*

Supplemental Questions

Medical Support Need

1. Does this person require exceptional support in response to any medical needs, or to mitigate exceptional medical needs? Exceptional support is defined as active 1:1 hands-on assistance for medical needs. **Support is p**rovided by a combination of a licensed registere**d** nurse (RN) and a direct support professional who is directly trained and supervised by an RN.

   Exceptional medical support may be needed for conditions including (but not limited to): Inhalation or oxygen therapy; postural drainage; chest PT; suctioning; oral stimulation or jaw positioning; dysphagia or swallowing difficulties; tube feeding; parenteral feeding; turning or positioning; dressing of open wounds; protection from infectious diseases due to immune system impairment; seizure disorder management; dialysis management; ostomy and catheter care; gastrointestinal health management; incontinence management; lifting and/or transferring; hypertension or hypotension management; allergies management; diabetes management; chronic pain management, arthritis management; management of conditions requiring specialized oral care, and/or other serious medical conditions.

   Yes ◯ No ◯

   a. Are these exceptional medical support needs are documented in a nursing plan signed by an RN?

      Yes ◯ No ◯

   b. How many days per week is exceptional support required to address medical conditions? On average, how many hours per day is specific exceptional medical support required?

      i. Number of days per week =

      ii. Number of hours per day=

   c. Describe the exceptional supports needed for medical conditions, including the roles of the people performing them today and how the needs should be met in the future. Describe the types of support (e.g., supervision of medication administration, hands-on assistance with cleaning and maintaining catheter), how often the support is needed (e.g., every morning, occasionally throughout the day), and how long the support takes (e.g., a few minutes before each meal, constantly).

Behavioral Support Needs

2. Does this person require exceptional support to address behavioral needs, or to mitigate exceptional behavioral needs? Exceptional behavioral support is defined active behavioral supports, constant observation, and availability of dedicated 1:1 assistance to prevent or mitigate behaviors that threaten the safety of the person or people in the community. Supporters require specialized training in positive behavior supports and apply strategies detailed in the positive behavior support plan with oversight from a behavioral therapist or comparable professional.

   Exceptional behavioral supports may be needed for (but not limited to): assault and/or injury to others; property destruction; stealing; self-injury, self-neglect; suicide attempts; pica; non-aggressive, but inappropriate sexual behavior; sexual aggression; substance abuse; wandering; maintenance of mental health treatments; or other serious behavioral and mental health needs?

   Yes ◯ No ◯

   a. Are these exceptional behavioral support needs are documented in a behavior support plan or crisis plan?

      Yes ◯ No ◯

   b. Has the person been charged or convicted of a crime related to these behavioral needs that involve**s** ongoing legal requirements or restrictions due to the charge or conviction?

      Yes ◯ No ◯

      i. If yes, please describe:

   c. Does the person have documented restrictions in place related to behavioral needs through the human rights committee?

      Yes ◯ No ◯

      i. If yes, please describe:

   d. How many days per week is exceptional support required to mitigate behavioral risks? On average, how many hours per day is specific exceptional behavioral support required?

      i. Number of days per week =

      ii. Number of hours per day =

   e. Describe the exceptional supports needed to mitigate behavioral or mental health issues, including the roles of the people performing them today and how the needs should be met in the future. Describe the types of support (e.g.,

	supervision, hands-on assistance to safely enter a vehicle), how often the support is needed (e.g., every morning, occasionally throughout the day), and how long the support takes (e.g., a few minutes as they get on the bus, constantly).
Flagging Criteria	
Medical	Affirmative responses to Supplemental Question 1, 1a, and hour threshold of 56 hours indicated in 1b.
Behavior	Affirmative responses to Supplemental Question 2, 2a, and hour threshold of 56 hours indicated in 2d.

Rate Tiers

For services with tiered rates, the rate tier to which a person is assigned is based on their support level. Since our original work determined that support needs were comparable across certain support levels (that is, the needs of people in the current Support Levels 3 and 4 were comparable, as were the needs of those in Support Levels 5 through 7), the seven current levels are crosswalked to four rate tiers as shown in the figure below.

Figure 5. Current Tier Crosswalk

Current Support Level	Rate Tier
1	1
2	2
3	3
4	3
5	4
6	4
7	4

As noted above, the proposed support levels are similar to current support levels and our analysis shows that most people will remain in the comparable support level and rate tier. As a result, we are not proposing changes to the rate tier to which each level is matched. The figure below adds the proposed support level to the existing crosswalk.

*Figure 6. Proposed Tier Crosswalk**

Current Support Level	Proposed Support Level	Rate Tier
1	1	1
2	2	2
4	3	3
5	4	4
6	M	4
7	B	4

*Previous Support Level 3 is not shown, the remainder of the support levels are comparable.

This crosswalk generally mirrors the current crosswalk. There are, however, some changes in the composition of each level so this project considered the adequacy of the rate tiers. This analysis did not review cost assumptions in the rate models used to establish payment rates (such as assumptions related to direct support professional wages and benefits or agency overhead costs); rather, we reviewed the amount of funded staffing assumed in the tiered rate models to meet people's support needs.

Because the proposed support levels would result in more people being assigned to a higher support level than to a lower level (although most people will remain in the level comparable to their current level), total funded staff hours (and total provider payments) would increase if the rate model staff assumptions are unchanged. Considering group homes for example, funded staff hours for existing residents would increase by an estimated 2.7% if no changes are made to the rate models. Assuming that current staffing assumptions are adequate, this would suggest that each tiered rate should be reduced so that providers receive the same level of current funding to support the same people they are supporting today. Neither DBHDS nor DMAS support rate decreases, however, so we proposed no changes to payment rates.

Based on current utilization levels and the maintenance of current payment rates, we estimate that the proposed support levels will increase total spending on tiered services by about $34.3 million in total funds (about 3% percent) once fully implemented. This impact will be phased-in over four years based on the existing SIS-A assessment schedule. Most providers of tiered services will experience an increase in revenues, but the actual impact will vary by provider based on the specific people they serve.

Policy and Practice Needs

Along with the updates to the support levels framework described above, we reviewed policies and practices that may require updating. These are outlined below.

Assessment Administration

Overall DBHDS uses strong SIS administration processes and maintains adherence to AAIDD's recommendations[20], for administering the SIS (e.g., assessor training, assessment schedule. DBHDS has also instituted protocols to improve its own administration, like the standard operating procedure previously noted. Though not a recommendation from this project, DBHDS also recently made a new allowance in the assessment administration. DBHDS begun allowing respondents to bring printed copies of person-centered plans to SIS assessments so that they can answer questions by referring to the current plans that they have in place. This change should help to clarify confusion over how respondents should answer some questions.

[20] www.aaidd.org

We identified additional changes that may support improved assessment administration.

Schedule assessments so people receiving services and their families can attend. Through advisory group meetings, we heard that people receiving services and their families are not always included in the SIS assessment. DBHDS follows the protocols outlined by AAIDD and requires that two qualified respondents attend the assessment. DBHDS also provides training to support coordinators outlining their responsibility to determine who to invite to the assessment, including people who know the person well. In the documented scheduling protocol[21], DBHDS also encourages the participation of the person receiving services and requires that their guardian be invited to the assessment. To better include family members and other informal caregivers, DHBDS can revise this scheduling protocol to suggest that support coordinators work with the person receiving services (and/or their guardian, if applicable) to identify family members and/or caregivers who should be included as respondents in the SIS assessment. These people would still need to meet the requirements for respondents.

Assessment Process

Set intentions for people and their families to speak up about their support needs in the SIS. Along with minor changes to the protocol to better include people and their families in the SIS scheduling, we heard that people may need encouragement to speak up about their needs. DBHDS might consider additional strategies to help people receiving services and their families to participate in the assessment and to share information about the person's support needs. In the Communication Plan section we share educational materials to provide people with more information about the SIS assessment and the role of people receiving services and their families. DBHDS also uses the SOP[22] to set expectations for the meeting, which can help people to feel more comfortable in sharing information about their support needs.

We propose adding language to the SOP to encourage family members to speak up and to clearly communicate that family members and other caregivers may serve as respondents. See suggested language changes in Appendix A. Another change that may be beneficial in encouraging people receiving services and their families to fully participate in the SIS assessment is to ask people and their families to start the meeting by sharing a bit about themselves and their interests. Since this project was initiated, DBHDS began allowing people receiving services and other respondents to bring person-centered plans to the SIS assessment in response to feedback from community engagement. DBHDS has also established a SIS interviewer intro that asks all respondents to share a statement of admiration. One additional method to start this conversation may be by allowing people receiving services or their families an to share their one-page profile from their person-centered plan

[21] https://dbhds.virginia.gov/assets/doc/DS/rsu/waiver/dbhds-sis-scheduling-procedures-10.29.2020.pdf
[22] https://dbhds.virginia.gov/wp-content/uploads/2023/05/DBHDS-SIS%C2%AE-Standard-Operating-Procedures-and-Review-Process-4.28.2023.pdf

to the meeting and to begin the SIS interview by sharing a bit about themselves. Of course, other methods may be used, such as additional questions added to the intro to set the tone in the meeting (e.g., What are your interests? Is there anything you want to share about the help that you need?). While DBHDS strives to empower people receiving services and their families to speak up about their support needs, having additional options may lead to more participation from the person and their family in the SIS assessment.

Supplemental Questions

Reduce and simplify the supplemental questions. The supplemental questions were added to the SIS assessment to identify people who may have exceptional medical or behavioral support needs that are not otherwise indicated by the SIS. If a person answers specific questions, they go through a document review verification. The document review verification uses documents to confirm whether the person has the specific needs. If the person has the specified needs, they are assigned to the medical or behavioral support level. As part of our work with DBHDS a decade ago, we assisted in the development of the four questions currently used. Over time, several other states that use supplemental questions have elected to reduce the number of questions and to ask more directly about the needs that they are seeking to identify. We similarly propose to change the supplemental questions to ease administration, update language, and better align with the information that document review verification seeks to confirm. These changes will support the document review verification committee to better identify people with exceptional support needs who may benefit from a higher rate tier.

Strengthen the document review verification process. We originally helped DBHDS establish the document review verification process and suggest some updates. First, given that the role of the document verification review process is to confirm medical or behavioral support needs, it may make sense to add members to the document review verification committee who have specific expertise in medical or behavioral support needs. Or people with this expertise may be called on to only review relevant records (e.g., a nurse reviewing the records of someone who has been identified as having exceptional medical support needs). Alternatively, DBHDS may only rely on such expertise when the committee has questions about the person's record or if they are unable to come to determination of whether the person should be verified.

DBHDS should review the form used to document verification decisions for any updates related to the proposed changes. DBHDS should also review the training or other documentation and materials used for document verification review to determine whether any updates are warranted as a result of our proposed updates. The proposed changes to the supplemental questions made as part of this project simplify the justification for the document review verification. Put simply, if the supplemental questions are accurately answered, document review verification will support those answers, and the person will be verified. DBHDS should continue to document how the person specifically meets the requirement (e.g., the person has a nursing plan in place signed by a registered nurse). If DBHDS elects not to verify someone, the documentation should reflect the discrepancies between the

person's responses and what is found through document review verification (e.g., the person does not have a nursing plan in place signed by a registered nurse).

Using SIS Results

Integrate the SIS into each person's plan. We heard from providers that previous SIS results are not always shared with them though this information would be helpful for planning for and delivering services. DBHDS currently requires that support coordinators provide the SIS Summary Report to people receiving services, their families, and all providers[23]. It is not specified how support coordinators provide these results, though they are not uploaded into the Waiver Management System (WaMS).

In the SOP, DBHDS provides a timeline and outlies options for providing the SIS assessment to the person and their family. DBHDS may provide more detailed guidance, however, about how the SIS assessment results are provided For example, if possible, DBHDS may ask that support coordinators upload the SIS into WaMS. If it is not possible for support coordinators to upload the assessment into WaMS or providers would not be able to adequately access the assessment through that mechanism, DBDHS may consider other methods to make the assessment electronically available to providers.

Beyond making the SIS assessment available to the person receiving services, their family, and providers, DBHDS should support efforts to integrate assessment results into the person's plan. This can be achieved by providing guidance to support coordinators either through training or through the support coordinator handbook about how the SIS information can be used to inform the support plan. Some ways that the SIS could be more integrated in the planning include the following.

- **IDENTIFYING THE PERSON'S STRENGTHS –** Within a good planning process, the team will not only note areas where a person needs support, but also the person's strengths. The SIS assessment can help identify these strengths.
- **GATHERING BASELINE DATA FOR PLANNING –** The SIS assessment may be used to provide baseline data as well as planning data for any outcomes on which a person is interested in working. For example, if a person is interested in attending a class or learning a new skill, the support coordinator could review the lifelong learning section to identify what types of support may be needed to help them be successful and monitor any improvements that person may make over time.
- **CONSIDERATION OF NEEDED SERVICES** – As the person's team is considering the need for supports, it should review the areas noted in the SIS assessment where support needs were identified and the level of support that was identified. The team can then make sure that the person and any service-related outcomes are aligned to the identified needs.

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[23] https://dbhds.virginia.gov/assets/Developmental-Services/developmental-disabilities-waiver/DD%2005-Support%20Coordination%20Handbook.%20Revisions%20June%202023.pdf

- **IDENTIFICATION OF STAFFING RATIOS OR SPECIALIZED SUPPORT NEEDS –** The SIS assessment provides detailed information about the intensity, type, and frequency of support required for someone to be successful in multiple life domains. Support coordinators should consider this information in determining whether any intensive staffing patterns are required or whether the person may need specialized supports (e.g., nursing oversight for a specific support).

If DBHDS wanted to better integrate SIS information into the planning process, providing examples and guidance to support coordinators may prove helpful.

System Analysis and Evaluation

Having used the SIS assessment for many years DBHDS has a wealth of data that can be harnessed to analyze trends in the system and evaluate how well specific policies are meeting the needs of people receiving services. Information generated by the SIS assessment and tier system can provide invaluable insight into how the system is performing and how people are served. Through key informant interviews, we heard a desire to make better use of SIS data. DBHDS can use SIS data for tracking basic metrics, specific initiatives, or planned changes, and how closely the implementation of the changes we propose matches our projections.

System Analysis

Track implementation of our proposal. First, we suggest that DBHDS consider an internal dashboard or reporting mechanism to track the implementation of the support level/rate tier updates. DBHS could track metrics such as:

- The number of people assessed with the SIS 2nd Edition
- The percent of people assessed with the SIS 2nd Edition assigned to each support level
- The percent of people assigned to rate tiers by service type
- Customized rate requests to understand how these may change as a result of changes to the tier assignments

Tracking these types of metrics will help DBHDS to better assess any unidentified implementation needs and to identify and resolve any challenges.

Use SIS information to track ongoing or planned initiatives. With this wealth of data, DBDHS could not only track implementation of the SIS 2nd Edition but could also explore how well other initiatives are working across people with various support needs.

For example, Virginia has been engaged in an Employment First! initiative for many years with the expressed intent of improving employment outcomes among people receiving services. DBHDS offers employment options to people receiving services prior to offering other options for services

and also has guidance around creating positive employment outcomes[24]. Related to DBHDS' settlement agreement with the Department of Justice pertaining to Olmstead provisions requiring that people be served in the most integrated setting, DBHDS reports semi-annually on the employment outcomes of people receiving services[25]. The reporting enables DBHDS to track improvement on the number of people employed in different types of work settings, the number of people with outcomes in their planning document, the wages that employed service recipients receive, and other important employment information. In order to determine whether employment aims are being met equitably across the service population, DBHDS could track the support levels of people employed and using employment services. Tracking this information would help DBHDS to consider whether changes are needed to employment services or whether enhanced training requirements should be implemented for staff delivering employment services.

SIS information could also benefit DBHDS' supported decision making initiative[26] to ensure that people receiving services remain in control of their lives. DBHDS offers training and information about how to establish a formal supported decision-making agreement on its website.[27] If DBHDS wanted to ensure that people with a range of support needs are able to access supported decision-making, DBHDS could track supported decision-making agreements by support level. If DBHDS learned, for instance, that people in higher support level were rarely offered the opportunity to engage in supported decision-making, DBHDS could provide targeted outreach to people in higher support levels to better understand the barriers they face and to brainstorm solutions. DBHDS could also work with interested parties, such as a workgroup of support coordinators or the Virginia Board for People with Disabilities to develop solutions to ensure that people can equitably access their rights to retain control over their decisions.

Though we provide select examples, here we suggest that DBHDS consider which current or planned initiatives may not be equitably applied across the service population. DBHDS can then consider whether data collection is feasible and whether reviewing any specific metrics can help to address policy challenges. Again, this could be a collaborative effort amongst any existing or future workgroups and partners.

Evaluation

***Conduct routine evaluation*.** Evaluation offers an opportunity to assess how well the support level/rate tier model will continue to meet people's needs after implementation. We recommend that DBHDS consider ongoing evaluation of the support levels/rate tiers and/or routine evaluations that can occur approximately every three-to-five years. This evaluation should, at a minimum, assess

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[24] https://dbhds.virginia.gov/developmental-services/employment/
[25] https://dojsettlementagreement.virginia.gov/dojapplication/external/documents/Dec-23-Semi-Annual-Employment-Data-Report.pdf
[26] https://dbhds.virginia.gov/supported-decision-making-supported-decision-making-agreements/
[27] https://dbhds.virginia.gov/supported-decision-making-supported-decision-making-agreements/

whether there have been any changes in the overall distribution of support levels and rate tiers and whether there have been any increases in requests for SIS reassessments and customized rates. If other changes have been made to the assessment processes or rates, DBHDS may want to analyze other information such as the tier crosswalk or requests for a review of the SOP. DBHDS should plan to time these evaluations with future rate studies so that DBHDS can be prepared to address any financial implications as part of an overview of provider reimbursement.

Areas Where No Changes Are Needed

At this time, we are not recommending changes to several aspects of the model including children's support levels, the SIS reassessment request process, and the customized rate process.

Due to the fact that there are few children who receive a Supports Intensity Scale-Children's (SIS-C) assessment and receive tiered services, and that the SIS-C is not changing at this time, we are not recommending any changes to the SIS-C. If DBHDS expands use of the SIS-C or applies tiered rates to more services that children frequently use, it may reconsider whether changes need to be made to the children's support levels/rate tiers.

DBHDS has a SIS reassessment process so that people can request another assessment outside of their regularly scheduled SIS assessments. DBHDS has Instructions[28] for its reassessment process on its website. A reassessment request can be made by the support coordinator from the Community Service Board (CSB) supporting a person six months after the SIS assessment takes place by completing a form from the DBHDS website[29]. Once submitted, the regional support specialist and the SIS review the form® quality manager for review and disposition.

Having a reassessment process is an important part of the overall SIS administration process. Given that assessments are regularly scheduled to occur approximately every three or four years, a person's needs can change in the interim. Having a means to address any changes through an earlier SIS can help ensure that people's assessments continue to match their needs. We are not recommending changes to the SIS reassessment process.

DBHDS has a very thorough customized rate process for providers to request exceptions to the tiered rates when they do not believe that they are adequate to support the needs of people receiving services. DBHDS posts important information about the customized rates process on its website including:

[28] https://dbhds.virginia.gov/assets/Developmental-Services/waiver/rsu/SIS-Reassessment-Request-Instructions-6.15.17.pdf
[29] https://dbhds.virginia.gov/wp-content/uploads/2022/12/DBHDS-VA-SIS-Reassessment-Request-8.17.2022.docx

- Customized Rate Provider Guidelines[30]
- Customized Rate Frequently Asked Questions[31]
- Customized Rate Application (submitted in WaMS)[32]
- Customized Rate Service Authorization Procedures[33]

Additionally, the ARC of Virginia hosts a video explaining this process that may be helpful for providers to review[34].

This customized rate process is very thorough and offers clear and detailed information about what is expected of providers and what types of rate exceptions will be approved. While we reviewed the customized rate process as part of this project, we do not recommend any changes to this process at this time.

[30] https://dbhds.virginia.gov/library/developmental%20services/provider_guidelines_customizedrate.pdf
[31] https://www.dbhds.virginia.gov/assets/doc/DS/rsu/waiver/provider-info-frequently-asked-questions.pdf
[32] https://dbhds.virginia.gov/library/developmental%20services/customized%20rate%20application.docx
[33] https://dbhds.virginia.gov/wp-content/uploads/2022/05/Provider-Info_Service-Authorization.pdf
[34] https://www.youtube.com/watch?v=5VmhIWJz-ZE

Background and Methods

To complete this work, we undertook several steps that are outlined below.

Consult People

- Convene an advisory group
- Interview Key Informants
- Host virtual engagement sessions

Analyze Changes to the Support Levels/Rate Tiers

- Review supplemental questions and verification process
- Analyze the new SIS scoring and the advanced questions
- Analyze the rate tiers
- Test the proposed changes with a record review

Recommend Changes to Support Level/Rate Tiers

- Propose final recommendations
- Develop a transition plan
- Develop a communication plan to help support the implementation

Consult People

We had three major activities to consult people: working with an advisory group, key informant interviews, and informational meetings for community members.

Advisory Group

To provide regular input throughout the project, we established an advisory group consisting of 22 people. Members of the advisory group represented:

- Service recipients
- Family members
- Providers
- Community Service Boards
- Advocates
- State staff

Over the course of this project, we held eight advisory group meetings. These meetings were every month, beginning in September 2023 through May 2024, with one meeting rescheduled to accommodate the project team's completion of analysis to be presented. Each advisory group meeting lasted for about one-and-a-half to two hours. Advisory group meetings were open to the public and generally attended by many members of the public. The focus of each advisory group meeting is summarized in the table below.

Figure 7. Advisory Group Meetings

Meeting	Advisory Group Attendees	Public Attendees	Content
1	17	26	First was an introduction of HSRI staff, state staff, and the Advisory Group members. This was followed by an overview of the project and planned project activities.
2	13	18	We gave an overview of the SIS-A 2nd Edition and why it was selected by DBHDS as the state's assessment tool, and of the current support levels and rate tiers.
3	13	55	We provided updates about informational sessions being held for the public. We then gave an overview of the medical and behavioral sections on the SIS and document review verification.

4	13	45	We gave an overview of key informant interviews that had been conducted. We then shared our plan for conducting analysis of the support levels and rate tiers.
5	12	48	We discussed the results of our preliminary analysis and what the impacts of our proposed changes would look like. We then led a discussion about support level labeling and ways to improve understanding of the support level framework.
6	10	37	We shared preliminary general support need levels and the preliminary medical and behavioral support levels. We then provided space for questions around the preliminary framework.
7	10	64	This meeting was focused on the record review that we had conducted. We gave an overview of the process and preliminary findings from the process. Our partners at HMA-Burns discussed rate tiers.
8	11	45	This meeting was spent discussing our preliminary recommendations, transition plan, and communication plan for DBHDS.

To facilitate conversation within the advisory group meetings, we structured the meetings so that each meeting consisted of a question-and-answer period, used chat, and Mentimeter[35] (an online tool to conduct interactive polls). We asked all attendees to complete a survey rating the effectiveness of the meeting and reviewed the results to identify potential improvements.

The general public was invited to request an invite for the advisory group meetings using a feedback form.

Key Informant Interviews

We convened eight key informant interviews with people or groups of people familiar with the day-to-day operations of the support level/rate tier model. These included interviews with:

- Developmental services leadership group to discuss aims of the project, budget, and service trends
- Department of Medical Assistance Services leadership group to discuss funding and budgetary trends

[35] https://www.mentimeter.com/

- Wavier operations director to discuss waiver timelines and policy as well as SIS administration and rates
- Quality manager to discuss SIS assessment administration and timelines, document review verification, and reassessment policy
- Regional supports manager to discuss training, SIS administration, exceptions, and rates
- Regional support specialist group to discuss verification, training, and reassessment
- Customized rate group to discuss rate exceptions
- Office of Integrated Support Services group to discuss systems used to assign tiers and levels, manage the rate system, and flag for document review verification

These interviews supported our understanding of current processes used by DBHDS to implement the support levels/rate tiers model. It also supported exploration of possible transition needs and areas where policy improvements could be made.

Informational Meetings

We also held three series of informational meetings. Each series included a separate meeting targeted towards people receiving services and their families, support coordinators, and providers, though the meetings were open to anyone. The informational meetings were meant to cover the following topics:

- **SERIES 1 –** The purpose of this meeting was to explain the SIS-A 2nd Edition project and to gain initial feedback from people about what changes they would like to see to the support level/rate tier model.
- **SERIES 2 –** The purpose of this meeting was to provider preliminary information related to the support levels and rate tiers.
- **SERIES 3 –** The purpose of this meeting was to share all the proposed findings to date as well as other recommendations and initial communication and implementation planning elements.

The figure below shows the number of attendees at each meeting.

Figure 8. Informational Meetings

Series	Meeting Date and Time	Audience	Number of Attendees
1	November 15, 2023 11:00am-12:45am EST	Providers	56
	November 16, 2023 10:00am-11:45am EST	Support Coordinators	58

	November 16, 2023 2:00pm-3:45pm EST	Recipients and Families	14
2	April 4, 2024 3:00pm-5:00pm EST	Support Coordinators	156
	April 9, 2024 1:00pm-3:00pm EST	Providers	171
	April 10, 2024 6:00pm-8:00pm	Recipients and Families	58
3	May 29, 2024 11:00am-1:00pm EST	Providers	46
	May 29, 2024 1:00pm-3:00pm EST	Support Coordinators	22
	May 31, 2024 1:00pm-3:00pm	Recipients and Families	98

Notices about these meetings were shared through e-mail listservs and by targeted outreach from DBHDS. We also asked that advisory group members share meeting notices with their networks.

These meetings were used to both provide information about the project and the work that had been completed to date, as well as to collect high level information and feedback from attendees. Each meeting had a question-and-answer session.

Feedback Form

In addition to the methods identified above, we used a feedback form to collect additional feedback from people who attended advisory group meetings, informational meetings, or who otherwise received the link to the form. The Google form asked whether people wanted to be included in the meeting invites for advisory group meetings, and whether they had any questions or additional feedback they wanted to share.

We received 106 responses on the feedback form. Overwhelmingly, the feedback form was used to sign up for meetings; 103 people asked to be included in the advisory group meeting invites. We also received questions or feedback from 26 people. Key topics included:

- Questions about changes in the SIS-A 2nd Edition

- Concerns related to the validity of the SIS assessment and the reliability of the SIS assessors
- The timeline on which a person receives a SIS reassessment
- Questions and concerns about rate tiers and the process by which they are determined

We addressed questions provided in the feedback form in our regular advisory group meetings and in a frequently asked questions document[36] related to this project. We reviewed feedback for potential improvements that can be made to the support level/rate tier model.

Analyze Changes to the Support Levels/Rate Tiers

Our project involved significant data analysis to determine our proposed support level/rate tier updates. We reviewed supplemental questions and the verification process, we analyzed the new SIS-A 2nd Edition scoring and the advanced questions, we analyzed the rate tiers, and we tested the proposed changed with a record review.

Review Supplemental Questions and Document Verification Review

Given the other changes proposed through this project, we decided to review whether the current supplemental questions and flagging criteria would meet the needs of DBHDS going forward. As described in the Proposed Updates section, we decided with DBHDS to update the supplemental questions.

Next, we explored the current flagging that is used to flag people for document review verification to determine whether any changes were warranted based on data collected from previous document review verifications. The current flagging criteria for verification is outlined below.

- Flagging for verification of Extraordinary Medical Risk:
    - Yes to Supplemental Question 1
    - Yes to SQ 1a
    - Yes to SQ 1c
    - At least 56 total hours per week of needed medical support
    - A 2 on any item in Section 1A of the SIS
- Flagging for Community Risk-Convicted:
    - Yes to SQ 2
    - Yes to SQ 2a
    - Yes to SQ 2b
    - Yes to SQ 2c
    - 2 on items 2,3, or 9 in Section 1B of the SIS
- Flagging for Community Risk-Non-Convicted:

[36] https://dbhds.virginia.gov/wp-content/uploads/2024/01/VA-SIS-A®-2nd-Edition-FAQs_010924-POST.pdf

    - Yes to SQ 3
    - Yes to SQ 3a
    - Yes to SQ 3b
    - Yes to SQ 3c
    - 2 on items 2,3, or 9 in Section 1B of the SIS
- Flagging for Self-Injury Risk:
    - Yes to SQ 4
    - Yes to SQ 4a
    - Yes to SQ 4b
    - Yes to SQ 4c
    - 2 on items 5,6, or 7 in Section 1B of the SIS

A person can be flagged for one or more supplemental questions. Everyone who is flagged for verification goes through the document review verification to confirm the needs identified in the supplemental questions.

We started by reviewing how many people in past years were flagged for document review verification and who were confirmed to have medical or behavioral needs. We found that about 3% of people flagged for verification are verified into a higher level. This low rate of verification indicated that there may be opportunity to refine the flagging criteria. Since other changes to the supplemental questions themselves narrow the questions so that only people with the highest support needs are identified, we reviewed whether any changes could be made to the hour thresholds used.

Using verification data from 2023, we found that about 32% of people were flagged for document review verification for either medical needs, behavioral needs, or both. We then applied different hour thresholds to determine whether they would lower the number of people who are flagged for verification but retain people who had been verified. If an hour threshold of 42 hours were applied for flagging for verification, 26% would be flagged for verification. If 56 hours were applied, 20% would be flagged for verification. If 70 hours were applied, 16% would be flagged for verification.

Finally, we applied the median hours for all assessments, noted above, of 70 hours of medical and 96 hours of behavioral support need indicated on the supplemental questions. If these criteria are applied, out of 3,694 assessments, about 16% would be flagged for verification: In all tested options, every person who was verified would have been flagged for document review verification. Though this finding may have justified using a higher hour threshold, DBHDS elected to maintain an hourly threshold of 56 hours for both medical and behavior which is aligned with both the median hours of people who were flagged for medical verification and the level of staffing other than shared staffing assumed in the rate models for the highest rate tier. We propose the following flagging for document review verification.

- Flagging for Medical Support Need
    - Yes to SQ 1

    - Selection made to at least 1 item in SQ 1a
    - At least 56 total hours per week of needed medical support indicated in SQ 1b
- Flagging for Behavioral Support Need
    - Yes to SQ 2
    - Selection made to at least 1 item in SQ 2a
    - At least 56 total hours per week of needed medical support indicated in SQ 2d

Analyze the New SIS-A 2nd Edition Scoring and Advance Questions

National SIS-A 2nd Edition Analysis

Prior to beginning this project, we analyzed a dataset collected from across the Unites States with a significant anonymized sample of over 160,000 SIS-A 2nd Edition assessments provided by AAIDD for the purposes of informing our analysis for states transitioning to the SIS-A 2nd Edition. Though we later completed an analysis specific to Virginia and it's SIS-A assessments, this early analysis allowed us to develop our approach to this project.

The purpose of our analysis on the national dataset was to determine:

- The most appropriate number of general support needs support levels
- Which subsections of the SIS-A 2nd Edition should be used
- What scores best create levels that include people with needs similar to one another and different than people in other levels

We note that this analysis was only used to determine general support needs levels and not medical or behavioral support levels.

We explored the data using latent class analysis (LCA), a statistical procedure that can be used to classify people into homogeneous subgroups using a set of data. Using LCA, we tested 21 models and compared them to one another with "fit indices" and other diagnostics that point to which model(s) best fit the data. The models that we tested included different numbers of general support needs levels based on either the Supports Needs Index or the sum of SIS-A 2nd Edition subsections A, B, and E of the SIS-A 2nd Edition (which is currently used by DBHDS to assign support levels). To determine which models fit the best we considered:

- The statistical fit of each model tested (see fit indices below)
- Whether groups are significantly different from one another
- Whether people can be assigned to groups from low to high need
- Whether needs align with what is known about the population
- Whether the model allows for criteria using sum scores

Appling the fit indices to the models we tested, the models that include the SNI and three or four support levels tested the best. LCA, however, does not determine the exact criteria. Instead, it points to the best fit for the data and can help to inform the criteria. The criteria are determined based on

what best approximates the LCA groups. We applied criteria to the data that approximated both a three-level and a four-level model.

Using these two models, we then completed general linear modeling (GLM) tests. GLM tests differences between levels in each of the subscales and can demonstrate that groups are different from each other. This test shows that both models yield significant differences among groups on the SNI subscales and large effect sizes as shown in the figure below.

Figure 9. General Linear Modeling Results

Model	SNI Subscales	R^2	df	M^2	F	η_p^2
SNI 4	A. Home Living	.64	3	331860.08	96027.51	.64
	B. Community Living	.73	3	367830.51	139791.80	.73
	C. Lifelong Learning	.69	3	394248.47	117303.23	.69
	D. Employment	.71	3	376401.52	130336.98	.71
	E. Health and Safety	.74	3	399560.99	152370.83	.74
	F. Social Activities	.80	3	490022.76	213347.06	.80
	G. Advocacy & Protection	.81	3	725854.64	228271.56	.81
SNI 3	A. Home Living	.61	2	468132.77	122270.39	.61
	B. Community Living	.68	2	513665.02	165168.39	.68
	C. Lifelong Learning	.64	2	550428.83	142024.37	.64
	D. Employment	.66	2	527642.33	157388.02	.66
	E. Health and Safety	.69	2	557645.53	177232.23	.69
	F. Social Activities	.73	2	670763.48	216045.88	.73
	G. Advocacy & Protection	.74	2	998450.57	231376.32	.74

Note: All GLMs significant at $p < .001$.

Using the support level models, we explored the mean score of each SIS-A 2nd Edition subscale by support levels We used these analyses to determine whether people can be assigned to groups from low to high need and that needs align with what we know about the population. These scores are shown in the figure below, with the labels on the bottom representing each SIS-A 2nd Edition subscale.

Figure 10. Mean SIS-A 2nd Edition Subscale Scores

SNI 4 Levels

SNI 4 Levels	A	B	C	D	E	F
Level 1	5.8	5.4	5.6	5.1	5.2	2.9
Level 2	8.3	8.6	9	8.4	8.5	6.7
Level 3	11	11.1	11.7	11.1	11.2	10.3
Level 4	13.6	13.8	14.3	13.6	13.9	14.5

SNI 3 Levels

SNI 3 Levels	A	B	C	D	E	F
Level 1	6.4	6.2	6.5	6	5.8	3.9
Level 2	9.7	10	10.4	9.8	9.8	8.6
Level 3	13	13.2	13.7	13	13.7	13.5

Using the LCA and the other analysis we were able to develop preliminary support level criteria and refine it. Together, these tests and other diagnostic statistics showed that models using SNI had a better fit than those using the sum of subsections A, B, and E, and that models with 3 and 4 levels fit best.

Following this analysis, we determined that we would conduct statistical analysis using a similar dataset from DBHDS to assess whether the data tested any differently. If the DBHDSs data tested similarly, a model that uses the SNI and 3 or 4 support levels would be the best fit. Because the medical and behavioral scores are not scaled, there are not meaningful statistical tests that could be used to determine criteria that fit the data. As a result, we used a different approach to determine the medical and behavioral support level criteria that was specific to Virginia's data as described in more detail in the next section.

Virginia SIS-A 2nd Edition Scoring Analysis

Following the national SIS-A 2nd Edition analysis, we began analysis on DBHDS SIS-A 2nd Edition assessments, repeating some of the analyses that we conducted with the national dataset. This analysis was intended to:

- Confirm whether using the SNI instead of the sum of Subsections A, B, and E better fit the data
- Determine whether there is a better model fit between 3 or 4 general support need levels
    - If there was no difference, we intended to allow policy to determine which option would work better
- Confirm findings on level assignment criteria based on national dataset LCA

We began our analysis for DBHDS using a dataset with demographic information for 17,459 people with active enrollment status between July 1, 2021, and June 30, 2023. We also accessed the 17,178 SIS-A assessments conducted between January 1, 2018, and December 15, 2023.

To prepare for data analysis we used advanced questions to calculate SIS-A 2nd Edition medical and behavioral score totals. We then applied SIS-A 2nd Edition norming tables to subscale scores. We then conducted LCA. The figure below shows the fit indices that we tested.

Figure 11. LCA Fit Indices

Fit index	Full name	What indicates better fit
AIC	Akaike information criterion	Lower value indicates better fitting model (similar to most explained variance)
BIC	Bayesian information criterion	Same as AIC, but stricter and considers parsimony (many prefer the BIC)
SABIC	Sample-size adjusted BIC	Same as BIC but also considers sample size
Entropy	-	Closer to 1 indicates classes are accurately defined, i.e., members of classes are more like those in same class than in other classes (over 0.8 is considered acceptable)
ALCPP	Average latent class posterior probability	Closer to 1 indicates high probability of a person being assigned to a class (similar to correlation)
VLLMR-LRT	Vuong-Lo-Mendell-Rubin adjusted likelihood ratio test	Significant test means that the model better than the null model (1 class)

We found that a model with 4 support levels best fit the data as shown in the figure below. The first row under the headings explains how we determined the best fit.

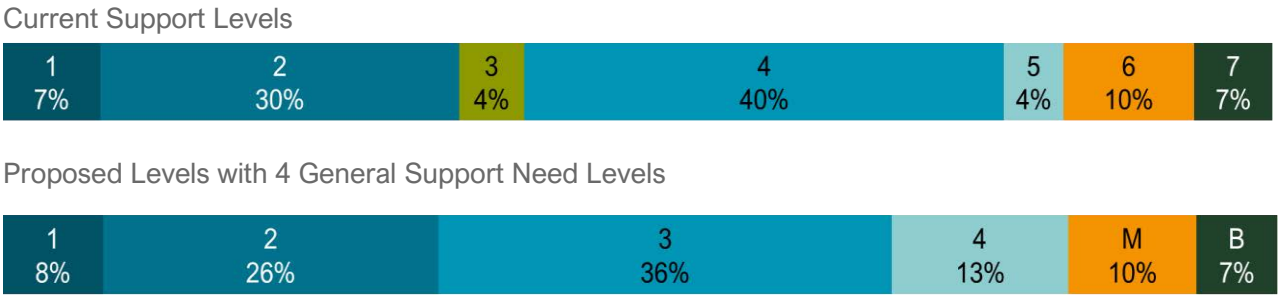
Figure 12. DBHDS LCA Results

MODEL	AIC	BIC	SABIC	ENTROPY	ALCPP	VLLMR-LRT
Better fit if...	small value	small value	small value	high value over 0.80	high value over 0.80	significant
SNI 8	457,644.09	458,184.60	457,962.15	0.86	0.87	1897.29
SNI 7	459,549.77	460,028.52	459,831.49	0.87	0.88	2513.78
SNI 6	462,079.88	462,496.85	462,325.24	0.86	0.88	2820.05*
SNI 5	464,920.18	465,275.38	465,129.19	0.88	0.91	6697.08**
SNI 4	471,687.37	471,980.80	471,860.03	0.90	0.93	13032.51**
SNI 3	484,871.56	485,103.11	485,007.77	0.90	0.95	27209.48**
SNI 2	512,414.80	512,584.67	512,514.76	0.90	0.96	58254.76**
SNI 1	571,402.59	571,510.70	571,466.20	-	-	-
ABE 8	208,130.43	208,392.96	208,284.91	0.76	0.76	246.86**
ABE 7	208,375.63	208,607.282	208,511.94	0.79	0.81	440.98
ABE 6	208,819.95	209,020.71	208,938.09	0.79	0.82	943.93**
ABE 5	209,780.16	209,950.03	209,880.12	0.80	0.85	2003.86**
ABE 4	211,827.55	211,966.54	211,909.34	0.83	0.89	4676.05**
ABE 3	216,615.85	216,723.95	216,723.95	0.83	0.91	10019.58**
ABE 2	226,885.09	226,962.30	226,930.53	0.79	0.93	17344.76**
ABE 1	244,667.88	244,714.21	244,695.14	-	-	-

Since this analysis confirmed the results of the national data set analysis, we proposed a four-level general support level model. Using the same process of creating criteria for the national dataset analysis, we used LCA results to create criteria for each support level, as detailed in the "Proposed Updates" section above.

We completed descriptive statistics on the data to determine whether the proposed support levels criteria met other statistical considerations such as aligning to what we know about the population. A distribution of the general support needs levels is shown below.

*Figure 13. General Support Needs Levels Distribution**



*For the purposes of showing the general support needs levels, at this stage in our analysis we retained the existing medical and behavioral support level criteria.

We also explored the impact of the proposed criteria by looking at how people's support levels would change if these criteria were applied and found that at this stage of the analysis 72% of people would remain in the comparable support level. We further tested the impact of the proposed changes by reviewing differences by waiver, disability, and age. We found no significant differences in the impact among any of the groups.

We then explored the impact of changes to the medical and behavioral sections.

Advance Questions Analysis

In addition to determining criteria for general support needs levels, we wanted to explore the impact of the advance questions on medical and behavioral scores and on support level assignments. We also wanted to explore other changes to the way that medical and behavioral sections are calculated for level assignments.

Following recommendations that we provided to create similar scoring between the original SIS assessment (implemented in 2004) and the SIS-A (implemented in 2015), DBHDS used a medical roll-up to compute medical scores. The medical roll-up made the scoring between both assessments equivalent. The medical roll-up involved selecting only the highest score of three new items that were added to the SIS-A medical section, along with items listed as "other" medical items. This had the effect of allowing for maximum score of one or two points (the highest score received for any item in this section) for all items. With no remaining original SIS assessments being used to determine rate tiers, this roll-up is no longer necessary. Additionally, AAIDD added the items to the SIS-A and SIS 2nd Edition because of the high number of people with these medical needs who completed the assessment. We propose counting all items in the SIS-A 2nd Edition, and only rolling up "other" items. This change alone would allow for respondents to receive up to 8 more points in the medical section of the SIS-A 2nd Edition.

We similarly propose counting all the new items in the medical and behavioral sections of the SIS-A 2nd Edition assessment. The medical section had 6 additional items and a removal of 1 item, with a total of 12 additional points (20 total new possible points when added to the removal of the roll-up) and 2 additional points in the behavioral section.

Next, we explored the impact of the new medical items in the SIS-A 2nd Edition. DBHDS collected data on the additional items added to the SIS-A prior to transitioning to the SIS-A 2nd Edition. This allowed DBHDS to explore options for updating the support level model based on how people are expected to respond to the new questions.

Of the 17,178 SIS-A assessments conducted between January 1, 2018, and December 15, 2023, 2,151 people had responses to advanced questions in the medical section of the SIS-A assessment. Of those, 854 people reported having at least some supports needs related to one or more of the new medical questions. Since there is no meaningful analysis to compare these scores, we reviewed the overall impact to the population, to which support levels people would change if the criteria were

adjusted higher, and whether people who would no longer be assigned to the medical level would be flagged for document review verification. Given the significant number of points potentially added to the medical section and the small number of people who would no longer be assigned to the medical level by adjusting the score only 2 points higher, we propose adjusting the medical criteria for Support Level M to 9 points. This proposal will have the effect of scoring up to 20 additional points towards the medical level, while only raising the criteria score 2 points higher.

Of the 17,178 SIS-A assessments conducted between January 1, 2018, and December 15, 2023, 2,155 people had responses to advanced questions in the behavioral section of the SIS-A assessment. Of those, 399 people reported having at least some supports needs related to one or more of the new behavioral questions. Given the small impact (less than 1 percent of people moving into Support Level B) of the behavioral advance questions, we propose keeping the behavioral criteria the same. This will have the effect of scoring two more possible points for the behavioral section with the same criteria implemented today.

Following the development of the medical and behavioral support level criteria we again reviewed the distribution (shown in the figure below) and the impact.

*Figure 14. Proposed Support Level Distribution**

*This analysis shows all general support needs levels and medical and behavioral levels for only the 2,155 respondents with advance question data.

After having proposed final support levels, we completed analysis on the rate tiers.

Rate Tiers Analysis

This project is not intended to incorporate a comprehensive rate study that evaluates provider costs. Given the changes in the composition of support levels, however, we reviewed staffing level assumptions to determine whether any adjustments were warranted.

In particular, we wanted to explore:

- How existing rate tiers align to the proposed support levels (e.g., there may be fewer support levels, but the same number of tiers)

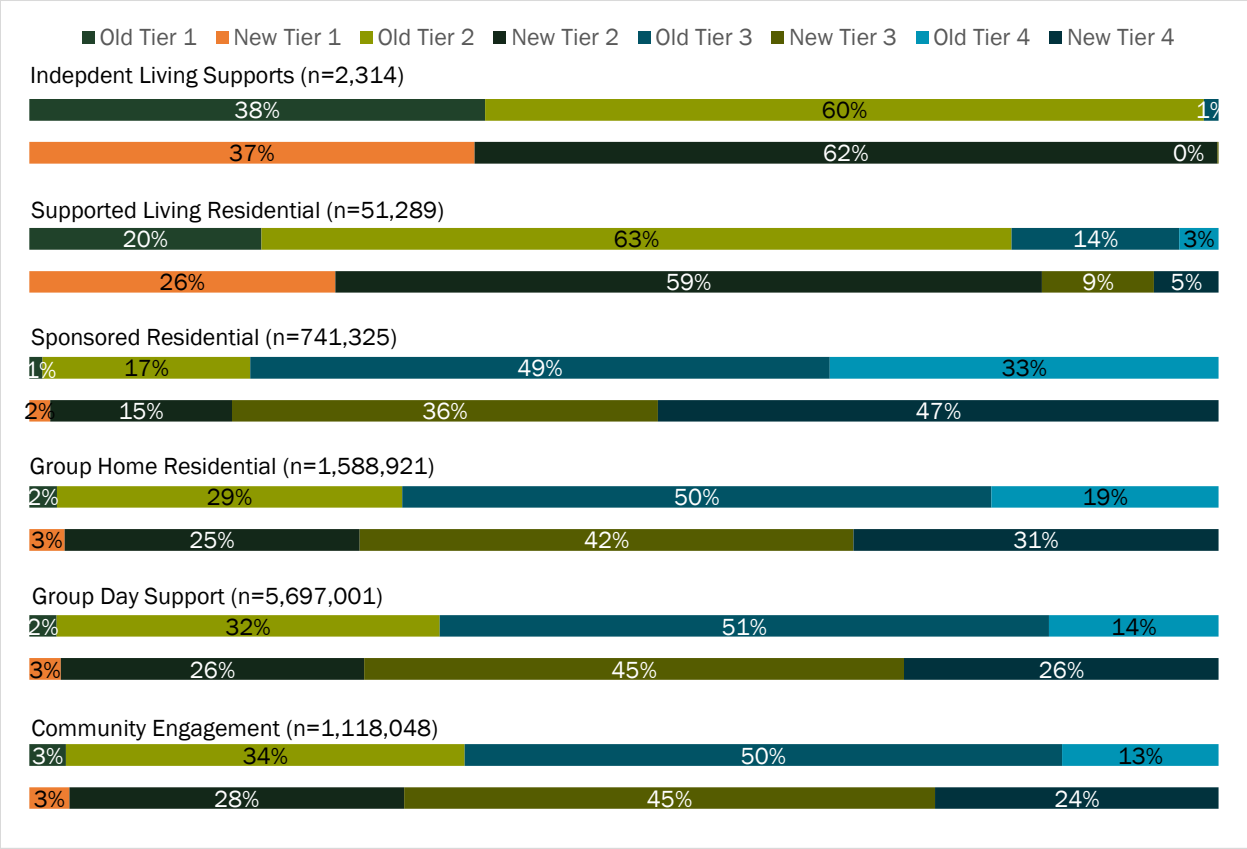
- Changes to the staffing assumptions in the rate models
    - For example, if the number of people in Tier 1 were to increase, that would suggest higher average needs in this group (because people formerly assigned to a higher tier are now in Tier 1), potentially necessitating more staffing
    - Or, if the number of people in Tier 4 were to increase, that would suggest lower average needs in this group (because people formerly assigned to a lower tier are now in Tier 4), potentially reducing staffing needs

As described above, overall, the proposed support level framework broadly mirrors the existing framework. That is, the proposed framework continues to include four general support needs levels as well as levels for people with exceptional medical or behavioral needs (although the proposed model eliminates Support Level 3 for people with significant but not exceptional behavioral needs, this impact is small). Further, the proposed support levels would assign a large majority of people to the level comparable to their current level. Thus, we do not propose changes to the crosswalk of support levels to rate tiers.

The proposed framework, however, would result in some movement in the composition of the support levels, with some people moving to a different support level. Given the changes in composition of each of the levels, we evaluated whether underlying staffing assumptions for each rate tier for each tiered service remained appropriate. For this analysis, we had demographic and claims data from 17,459 people receiving services from July 1, 2021, to June 30, 2023.

We completed this analysis by reassigning claims to the appropriate rate tier based on each person's support level using the proposed criteria. We compared the results to actual claims as shown in the figure below

*Figure 15. Current and Future Tiers by Service Type**



*Tiers are shown by units of service.

This analysis did show that there were changes in the tiers, and therefore, potentially the support needs of people assigned to each tier. Since more people would be assigned to a higher level than to a lower level, the composition of each rate tier includes people with somewhat lower needs. For example, the second rate tier includes some people who are currently in the first tier, the third tier includes people who are currently in the second tier, and so forth. When we evaluated the impact on group home services, we found that funded staff hours would increase by about 2.7%. Since the people themselves have not changed (only the criteria to assign support levels would change), this suggests that staffing levels (and, therefore, rates) should be reduced to maintain current funding and staffing levels. DBHDS and DMAS, however, determined that rates (via reduced staffing assumptions) would not be reduced as part of this project.

We then considered whether the changes in tier assignment warranted any changes to the tier crosswalk (described in Proposed Updates). Since most people will not change tiers, the current tier crosswalk will continue to meet DBHDS' needs.

Record Review

We next facilitated a record review process to test the proposed support level framework. The record review is intended to ensure that the proposed support levels will accurately reflect most people's needs when implemented. The questions that we answer through record review include:

- Do general support needs increase from low to high?
- Do people assigned to medical and behavioral levels have exceptional needs?
- Do people in the same support level have similar support needs?
- Do support level descriptions accurately reflect support needs?
- How can support level descriptions be improved?

We worked with DBHDS to identify19 people to review records. The people who participated served in various capacities, including a nurse and a behavioral therapist as well as CSB staff. We identified 127 people whose records they reviewed. DBHDS collected and provided access to records to each of the 19 reviewers. We asked the reviewers to review the records and compete a form documenting each person's support needs prior to an onsite meeting where teams discussed the records together.

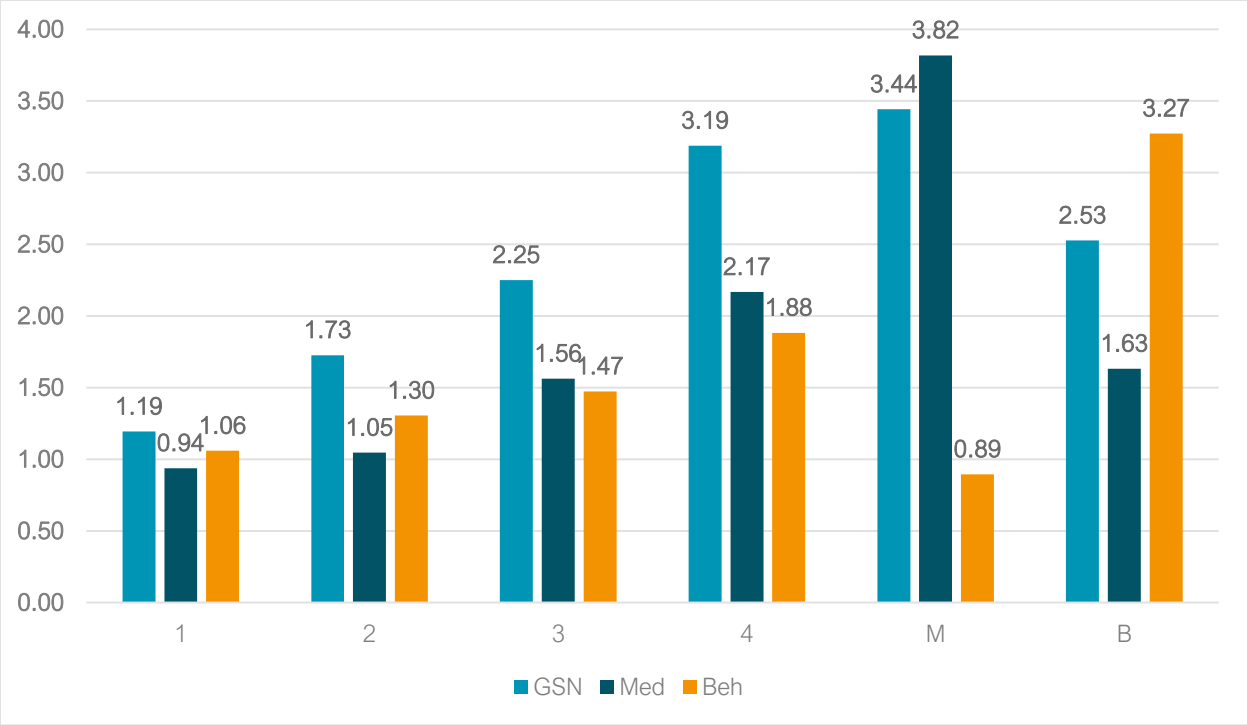
At the onsite meeting, we had four groups of reviewers. Each reviewer discussed the records they reviewed and shared their findings from the form they completed in advance. Each group then filled out another form indicating the intensity of the supports that the person needed from low to extensive for several general support need areas as well as medical and behavioral support needs. The figure below shows the rating scaled used for the general support needs, though the options were similar for medical and behavioral support needs.

Figure 16. Record Review General Support Needs Rating Key

None	The adult does not require any support in this area.
Low	The adult requires no support, monitoring, or verbal/gestural prompting for this support area. They may have a few intensive needs, but their support most often looks like prompting or supervision.
Moderate	The adult requires verbal/gestural prompting or partial physical assistance for this support area. They may require more or less assistance for some aspects of the support area. However, considered across all supports in this area the needs are more than prompting but not substantial. The majority of participants have moderate needs in most areas.
High	The adult mostly requires partial physical assistance or full physical assistance for this support area. This support may be a combination of prompting, supervision, and physical assistance but full physical assistance must be needed for at least some portion of the activities within this support area. At least some support is needed at all times the adult is engaging in the activities in this support area.
Extensive	The adult requires complete or almost complete physical support for most, if not all, aspects of this support area. Focused and dedicated support is needed at all times the adult is engaging in the activities in this support area.

The groups rated each person without having reviewed the person's proposed support level. Average rating for people in each proposed support level are shown in the figure below.

Figure 17. Average Record Review Ratings for All General, Medical, and Behavioral Areas



The record review found that the overall general support needs increase in support levels 1-4 and the medical level. The medical level was rated the highest for medical support needs. Similarly, the behavioral level was rated the highest for behavioral support needs. These results show that the support level framework work as intended. Through the record review, we found no strong indicator for changing the proposed support levels.

Fiscal Impacts

Following the decision to maintain current payment rates, we analyzed the estimated cost. To complete these analysis, we repriced fiscal year 2023 claims as if people had been assigned to a rate tier based on the proposed support levels. To determine the full impact of the cost, and acknowledge the limited data available to determine new medical and behavioral support levels (with only 2,155 people having responded to the new questions) we elected to assign new rate tiers for everyone except people who would be assigned to the medical support level, in effect holding their costs constant for the purpose of our analysis (that is, we know that some people in the current exceptional medical support level will not meet the new higher criteria while some people who are not currently in the level will move to the level due to the additional scoring opportunities with the new medical questions, but we have no basis for identifying those people who will move in either direction).

Using these the proposed tiers and holding people in the medical support level harmless, we repriced the claims with the new tiered rates and looked at the cost of fully implementing the proposed updates over the course of four years when we expect that everyone will have completed a SIS-A 2nd Edition assessment.

Our analysis found that spending will increase by approximately $34.3 million in total funds at current enrollment and utilization levels, about a 3% increase in spending on tiered services. This represents the cost at full implementation—once everyone has received an assessment using the SIS-A 2nd Edition. Given that the current assessment cycle is four years, the full cost will not be realized until approximately fiscal year 2030.

We also reviewed impacts for individual providers. Most providers of tiered services will see an increase in total revenues, ranging from a nominal amount to more than 20% in revenue. However, some providers will see a decrease in revenue as a result of the people they serve being assigned to a lower level. In general, expected decreases will be less significant than the expected increases. For example, about 14% of group home providers would ultimately experience a reduction in revenues, but the decreased would be less than 5% percent for four-fifths of these providers.

Recommend Changes to Support Levels/Rate Tiers

Following our proposals for changes, the record review, and the analysis of payment rates, we recommended that DBHDS move forward with the proposals that we outlined.

Transition Plan

Overview

Since the changes that we have proposed generally mirror and supplement current practices, we do not anticipate transition being overly burdensome. There are, however, still actions that need to be taken to support transition to the proposed updated support level/rate tier model.

Implement Support Levels

Since we have proposed changes to the support levels, these will need to be updated everywhere in DBHDS' systems. For example, DBHDS uses a process that relies on running a macro on SIS results retrieved from SISOnline every Monday to determine a support level and rate tier. The results are then uploaded to WaMS. DBHDS has already begun the work of developing the new algorithm to assign the support levels and rate tiers. In the future, DBHDS may wish to consider updating its WaMS system to automatically calculate support levels and rate tiers.

DBHDS will need to update the crosswalk between the support levels and rate tiers to ensure that the proper rate is being paid for each support level. DBHDS elected to retain four rate tiers, having

made this decision may simplify some of the changes since the Rates Management System relies on these four tiers, and any additional tiers would have likely necessitated a need for additional rates work to update the tier crosswalk. Regardless, it is critical that DBHDS update the tier crosswalk with the proposed support levels in every system that relies on this information.

Currently SIS information is not stored in WaMS; instead, only support levels and tier assignments are input. While this process is sufficient for the time being, DBHDS may want to consider whether more automatic processes can be put in place. For example, DBHDS may want to consider whether an application programming interface (API) can be implemented with SISOnline to eliminate the need for manually downloading SIS assessments from SISOnline or to automatically upload SIS Summary Reports into WaMS so that everyone who needs this information can easily access it.

Finally, if possible, DBHDS may consider integrating its WaMS system with the Rates Management System to eliminate manually uploading of results in that system as well.

Test Support Levels

DBHDS wants to ensure that the support levels and resulting rate tiers are accurate. After developing the new adult support level algorithm, DBHDS should thoroughly test the algorithm to ensure it is working properly. DBHDS should test:

- Whether the adult algorithm is being properly applied to all adults
- Whether the child algorithm is being properly applied to all children
- Whether the new scoring matches to the outlined criteria

As part of our project, we have begun testing the support level criteria with DBHDS. This criteria, however, should again be tested when DBHDS assigns support levels and rate tiers after the implementation of the SIS-A 2nd Edition.

To test the support levels, DBHDS should use a process similar to the following at least annually, or when any changes have occurred (e.g., the SIS download for SISOnline has changed).

First, DBHDS should download all assessments in SISOnline for both children and adults. DBHDS should apply the updated criteria to each assessment, ensuring that the adult criteria are only applied to adult assessments and that the child criteria are only applied to children assessments.

DBHDS should work with someone who can independently program the criteria to assign support levels by reviewing the criteria and policy protocols. This may be performed in the manner that most feasible for DBHDS, for example a Python script may be developed that can be run on a .csv file of SIS assessment data.

Next DBDHS should merge and compare the macro-output and the output resulting from the alternative process to ensure an exact math. If different results are produced for any record, DBHDS will need to resolve any inconsistencies by identifying and fixing either the macro or the alternative

process. If any discrepancies are found, DBHDS should document the discrepancy and the implemented resolutions, and rerun the test until there is an exact match for all records.

Secure Funding

As described above, we estimate that the proposed support levels will increase total funds spending by approximately $34.3 million, over the course of the four years in which it will be implemented. This does not account for any changes to payment rates or enrollment growth (e.g., eliminating the Priority One Waitlist. To the extent that DMAS cannot absorb this increase within its existing resources, it will need to seek additional appropriations through the state's budgeting process.

Update Administrative Code

Within its administrative rules, DMAS outlines specific references to the SIS assessment, current support levels and rate tiers, and supplemental questions. These rules will need to be amended to reflect the proposed changes. We outline suggested changes to the language in these rules in Appendix B.

Due to the time required for the rulemaking process, DMAS will not be able to update these rules prior to implementation of the SIS-A 2nd Edition. DMAS instead will may update the DD waiver manual[37]. Updating the manual will involve a review by the Governor's Office as well as a public comment period. Along with posting the manual, DBHDS may post a memo listing the manual updates (including updates the rate support levels) to inform people of coming changes in the interim.

Update Waivers

Currently, DMAS has information about the SIS assessment, 7 support levels, and connection to rate tiers noted in each of its three Medicaid Section 1915(c) waivers. DMAS should amend the waivers to accommodate the proposed changes. As with the administrative rules, these updates are generally minor. We provide suggested language for these changes in Appendix C.

Updating Other Policies, Protocols, and Training

In addition to updating the administrative code and waivers and implementing other policy and practice changes identified elsewhere in this paper, DBHDS may need to inventory additional policies, protocols, and trainings for changes related to our proposal. For example, the Support

[37] https://vamedicaid.dmas.virginia.gov/pdf_chapter/developmental-disabilities-waivers-bi-fis-cl-services#gsc.tab=0

Coordinator Handbook[38] references seven levels. There may be other DBDHS forms or training materials that also have outdated references that our project did not uncover.

DBHDS may consider an inventory to review all SIS related materials for references that should be updated to either more generally say SIS or to reflect the change in name to the SIS-A 2nd Edition. DBHDS should also consider any policies, protocols, or training that refer to seven support levels or that reference the crosswalk in an outdated way (e.g., reference to support level 3). Some resources may no longer be needed. Some documents that may require changes related to outdated references include the following:

- Supports Intensity Scale FAQs for Individuals and Families[39]
- Customized Rate Provider Guidelines[40]
- Supports Intensity Scale® (SIS) and the Person-Centered Process (PCP) in Virginia[41]
- Rating of Exceptional Medical Support Needs SIS vs. SIS-A
- Document Review Verification Template

There are likely other internal protocols, forms, or training that have additional outdated references. We suggest that DBHDS ensure that all related references align to our proposed updates and the changes within the SIS-A 2nd Edition assessment itself (e.g., the name of the assessment, labels of subsections).

[38] https://dbhds.virginia.gov/assets/Developmental-Services/developmental-disabilities-waiver/DD%2005-Support%20Coordination%20Handbook.%20Revisions%20June%202023.pdf
[39] https://dbhds.virginia.gov/assets/doc/DS/rsu/sis-faqs-individuals-and-families-3-20-2017.pdf
[40] https://dbhds.virginia.gov/assets/doc/DS/rsu/waiver/form-pg-20.pdf
[41] https://dbhds.virginia.gov/wp-content/uploads/2022/09/sis-pcp-process-in-va-7-22-20-SIS-A®-sis-c.pdf

Communication Plan

Overview

Throughout this project, DBHDS has taken effort to minimize the risk to people receiving services and their families. This has resulted in a proposed model where we expect that most people receiving services will remain in the same or a comparable support level. Even so, there are changes to the assessment, the model, and possibly related policies that will need to be shared through communications with people receiving services and their families, providers, support coordinators, and other interested parties. In this section we outline changes that need to be communicated and how these changes may be communicated, along with ongoing informational and communication needs.

Communicate Changes

First, we suggest that DBHDS communicate any proposed updates that it adopts. It is important that DBHDS communicate with all interested parties that there are forthcoming changes, particularly since some of the proposed updates may cause confusion or because they may be immediately noticeable which may lead to concerns about transparency if people have not been informed.

Changes that should be communicated include:

- Use of the SIS-A 2nd Edition – DBHDS intends to begin using the SIS-A 2nd Edition in October 2024. Prior to using this new assessment people receiving services, support coordinators, and providers should be informed about the change.
- Changes to the support levels – The support levels are changing as a result of this project, and while the comparable support levels are still matched in the same way to the tier crosswalk, with the removal of Support Level 3, the labels of the support levels have changes. These changes, in particular, may create confusion for people receiving services as even if they are assigned to the comparable level, it may seem that their level is being reduced.
- Change to any policies or practices – If DBHDS changes any existing policies, for example the document review verification process, DBHDS will want to make sure that responsible people have been informed of and are prepared to enact the changed policies.

Any materials that are produced should be made as simple and understandable as possible, so that they can be understood by a wide range of people, including people with disabilities. It is important that DBHDS outline why it is making these changes now. DBHDS should communicate the changes that are forthcoming to the SIS-A 2nd Edition and the need to update the support level/rate tier model as a result.

There are several avenues through which to share this information including:

- Listserv
- Quarterly SIS training
- Provider quarterly round tables
- 101 training for new support coordinators
- SIS letter

DBHDS should be prepared to include general updates related to our proposal through all of these different mechanisms so that as many people as possible are knowledgeable about these updates.

In order to mitigate confusion over the changes in the support levels labels, DBHDS should prepare a letter specifically outlining how the labels have changed in the tier crosswalk. This letter could illustrate the comparable support levels in the current and proposed support levels. This letter could be provided to people receiving services and their families when they receive a copy of their SIS Summary Report. Ideally, such a letter would be provided with any information shared with people receiving services and their families that details their support levels and rate tiers.

Education to People and Families

Throughout this project, we heard from people receiving services, family members, providers, support coordinators, and others that they wanted more education and information about the SIS, support levels, and rate tiers. Currently, DBHDS provides education and information about the SIS assessment through:

- A website that includes different information about the SIS and rates[42]
- The SOP document that is provided to each person prior to their SIS assessment[43]
- During the SIS assessment, each person gets a copy of the SIS assessment to review
- Quarterly training regarding the SIS, support levels, and rate tiers that is available to anyone who wants to participate

Although, DBHDS provides a significant amount of information to people receiving services, their families, providers and others, this information may be difficult to find, may include outdated references, or may not provide the level of detail that people hope to see. For example, DBHDS has a PowerPoint describing what the SIS is in a simple way, however, this PowerPoint is not housed in the same part of the website that houses other SIS information[44]. Additionally, the PowerPoint may be outdated with the forthcoming SIS-A 2nd Edition. Further, if people with disabilities and the families searched reviewed DBHDS' SIS tab, it may not be clear what they should review. Formatting this section of the website could help people more easily find the resources that they may be interested in reviewing. For example, DBHDS may first provide an explanation of what each resource is in addition to the title of the resource (e.g., If your needs have changed and you would like to request a reassessment, please work with your support coordinator to submit a SIS Reassessment Request).

Finally, the website itself may be difficult for people and families to use. Many of the resources that people receiving services and their families may find helpful are located under a tab (Waiver Services) that may not be a known term to people receiving services. If a search is performed for "Supports Intensity Scale" it yields zero results. To help people find resources on the website, it may be helpful to shorten the brief description of what kinds of resources are available in each tab, displaying them at all times, and linking to more detailed resources. This might give people a quick navigational menu to help them more easily find what they need. DBHDS should also ensure that all relevant resources can be retrieved through a quick search.

A quick overview video and handout is a good way for people to develop understanding about complex processes. Some of the resources included on DBHDS' website are written in simple text, it might, however, be helpful to provide a few plain language, audio, or video overviews of the assessment, support levels, rate tiers, or other policies and procedures people should be informed about. DBHDS provides links to AAIDD's website and specific respondent resources. Such as videos explaining what the SIS is[45] and how to read the SIS Summary Report[46]. Resources such as

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[42] https://dbhds.virginia.gov/developmental-services/waiver-services/
[43] https://dbhds.virginia.gov/wp-content/uploads/2023/05/DBHDS-SIS%C2%AE-Standard-Operating-Procedures-and-Review-Process-4.28.2023.pdf
[44] https://dbhds.virginia.gov/assets/Developmental-Services/waiver/rsu/sis-for-individuals-and-families-4-30-18.pdf
[45] https://www.youtube.com/watch?v=Catxfov8Ajc
[46] https://www.youtube.com/watch?v=udk2pC5h2-k

these can enable people to dig deeper into topics they want to know more about and develop deeper understanding about their role in the support level/rate tier model.

The ARC of Virginia has created a three-minute webinar series[47] that covers what the SIS assessment might look like and how the SIS score will influence the level assignment. Providing a link to this video on DBHDS' website can help people find quick and helpful information about the assessment. We note that, in this series, seven support levels are mentioned. DBHDS may find existing resources or look to create its own.

Other programs throughout the United States have developed materials related to the SIS assessment or how the program is using it. If DBHDS wants to create any new materials to enhance education, it may consider ideas from resources created by other jurisdictions. A video developed by Advocates in Action Rhode Island[48], gives an overview of the SIS assessment and answers frequently asked questions aimed towards advocates. Disability Rights North Carolina[49] created a video to explain the entire process of receiving a supports budget based on the SIS assessment. DBHDS may also look to partner with other organizations who may be interested in developing plain language, or multimedia resources, such as the Virginia Board for People with Disabilities. Should DBHDS produce any additional information it should include a link to DBHDS' website and, if possible, contract information.

As much as is possible DBHDS should find opportunities to provide context about support levels/rate tiers (e.g., the difference in support needs and costs for someone who is assigned to a Support level 1 vs. Tier 4). DBHDS may consider providing profiles of fictional, or real people (with permission) that help to make the support levels and rate tiers more concrete. These profiles may be based in data analysis and show the types of support needs the people have at each support level, what services they need that align to their SIS results, and what the tiered rates that they receive pay for. Such profiles could be used for many purposes, including highlighted in education materials that are posted by DBHDS for people receiving services and their families as well as, CSB staff, support coordinators, providers, and even DBHDS staff.

Education to CSBs, Providers, Support Coordinators, DBHDS

Throughout our project, we heard from many professionals, a desire to have more education about the SIS, support levels, and rate tiers. For example, support coordinators expressed a desire for providers to have training on the rate tier process, how it works, and their role in customized rate exceptions and other processes. Professionals from all levels included CSB staff, support

[47] https://www.youtube.com/watch?v=8zzuoc6809U
[48] https://www.youtube.com/watch?v=Op-1-1D1oZQ
[49] https://www.youtube.com/watch?v=52Dk0wE6Smo

coordinators, and DBHDS staff would all benefit from training related to the support level/rate tier model.

We recommend that Community Resource Consultants (CRCs) provide this training when a new provider starts as part of an onboarding process for new providers, and have provider specific materials that simply explain rate tiers that can be referenced

Across multiple professionals DBHDS offers opportunities for people to learn about the SIS, support levels, and rate tiers. Currently DBHDS offers SIS training for CSB staff quarterly. DBHDS offers a new provider training that includes infomration about the support level/rate tier model. DBHDS also offers comprehensive guidance for providers on how to go through the customized rate process. It may be useful for DBHDS to expand the guidance on the customized rate process to include more details overall about how the SIS is used, and how the support level/rate tier model works. Having this information in a single document may help all professionals to better understand different aspects of the model and quickly answer questions that they have. Michigan's Department of Health and Human Services maintains a SIS implementation manual[50] that details every relevant policy related to the SIS administration.

Professionals will likely benefit from many of the same materials that people receiving services find helpful. There may, however, be more detailed information that professionals require to fulfill their responsibilities, or to develop deeper understanding about why DBHDS has implemented a support level/rate tier model. It may be worthwhile to house a recording of support coordinator and/or provider trainings related to the support level/rate tier model on DBHDS' website. This will enable professionals to access these materials when it is convenient for them.

Whatever methods are chosen to enhance the education of professionals, DBHDS should make sure that all materials include consistent messages pertaining to why DBHDS uses a support level/rate tier model, why DBHDS uses the SIS assessment, and why specific policies and practices are in place.

DBHDS, also has several current workgroups that may require direct education. For these workgroups, we recommend that DBHDS share any developed materials as well as hold time on the agenda for direct education and discussion. These workgroups include the SIS stakeholder group, the systems issue resolution workgroup, and the provider issue resolution workgroup. Providing education to these workgroups will prepare them to better understand the changes as they work to alleviate challenges

[50] https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder14/Folder1/Folder114/MDHHS_SIS_Manual_Version22.pdf?rev=fb06d3752acc4ba39e61621cafee1862

Appendix A: Suggested Language Changes for SOP

Below we propose changes to the language in the current SOP[51]. Additions are shown in blue, and deletions are ~~stricken through~~ and shown in red. We also recommend that this document be edited so that it is more plain language.

A "Respondent" is defined as a person who has known the individual well for at least the last 90 days and has observed the individual closely in one or more environments for substantial periods of time. The 90 days must occur following an individual's assignment in the Waiver Management System (WaMS). Respondents are identified by ~~to~~ the assigned Support Coordinator (SC).~~, the assigned~~ People receiving services, their guardians, their family members, or other caregivers may be respondents. The SC may also participate in the individual's SIS® interview as a respondent.

2. Unless otherwise indicated, it is expected that the individual participates as a respondent in ~~his/her~~ their interview. The individual is free to choose his or her level of participation in the interview and is encouraged to share information about their support needs. Regardless of the individual's participation level, the SIS® Interviewer must meet the individual.
3. Legal guardians must be invited to participate in the SIS® interview.
4. The individual may have also selected family members and/or other caregivers to participate in the SIS. Family members and/or caregivers who are respondents are encouraged to share information about the person's support needs.

[51] https://dbhds.virginia.gov/wp-content/uploads/2023/05/DBHDS-SIS%C2%AE-Standard-Operating-Procedures-and-Review-Process-4.28.2023.pdf

Appendix B: Suggested Waiver Changes

Below we identify changes that will need to be made to the language in each of the three 1915(c) waivers. Outdated language is highlighted.

Outdated references can be found in the following locations in the Community Living Waiver VA.0372.R04.15 - Mar 01, 2024 :

- P. 15

  "For individuals in levels 6-7: The DBHDS customized rate review committee will meet upon application submission to review the submitted criteria. Subject matter experts in both medical and behavioral will determine if the need for a customized rate exists. After the determination is made, the rate model will be used to determine the rate approved."

  AND

  "For individuals in level 1-5: If the individual for whom the provider is requesting a customized rate falls within levels 1-5, a second level review will occur in which a community resource consultant (CRC) will contact the provider to conduct site visit/review. The purpose of this review is to assure that current services are being maximized, and that all community resources and supports have been explored. Following the site visit, the CRC can:.."

- P.69, 104, 139, 156, and 160

  "INDIVIDUALS ELIGIBLE FOR THE CUSTOMIZED RATE: These extremely medically fragile and/or behaviorally challenged individuals are those whose support needs place them in levels six or seven but who have a higher level of need than will be accommodated by the tier four rates, as well as any individual for whom it is determined that the only other resource is to be served out of state, in a state operated mental health or DD facility, or in a more restrictive environment. They are identified as those who require greater support in order to find in-state providers willing to serve them. These individuals' needs outweigh the resources provided within the current waiver rate structure."

- P. 304

  "Analysis was conducted to use Supports Intensity Scale® (SIS®) assessment data to create 'tiered' rates for residential and day habilitation services to recognize the need for more intensive staffing for individuals with more significant needs. Specifically, each member is

assigned to one of seven levels based on assessment results in the areas of home living support needs, community living support needs, health and safety needs, medically related support needs, and behaviorally-related support needs. These seven levels, in turn, are cross-walked to four rate categories: low needs (level 1), modest needs (level 2), moderate to significant needs (levels 3 and 4), and highest needs (levels 5, 6, and 7)."

Outdated references can be found in the following locations in the Family and Individual Support Waiver VA.0358.R05.04.15 - Mar 01, 2024 :

- P.20

  "There is a small cohort of individuals (particularly individuals being discharged from the Training Center who are extremely medically fragile and/or behaviorally challenged), for whom customized rates for this service will be necessary. These extremely medically fragile and/or behaviorally challenged individuals are those whose support needs place them in levels six or seven but who have a higher level of need than will be accommodated by the tier four rates, as well as any individual for whom it is determined that the only other resource is to be served out of state, in a state operated mental health or DD facility, or in a more restrictive environment. They are identified as those who require greater support in order to find in-state providers willing to serve them."

- P. 22

  "For individuals in levels 6-7: The DBHDS customized rate review committee will meet upon application submission to review the submitted criteria. Subject matter experts in both medical and behavioral will determine if the need for a customized rate exists. After the determination is made, the rate model will be used to determine the rate approved."

  AND

  "For individuals in level 1-5: If the individual for whom the provider is requesting a customized rate falls within levels 1-5, a second level review will occur in which a community resource consultant (CRC) will contact the provider to conduct site visit/review. The purpose of this review is to assure that current services are being maximized, and that all community resources and supports have been explored. Following the site visit, the CRC can:.."

- P.68, 73, 104, 158,

  "These extremely medically fragile and/or behaviorally challenged individuals are those whose support needs place them in levels six or seven but who have a higher level of need than will be accommodated by the tier four rates, as well as any individual for whom it is determined that the only other resource is to be served out of state, in a state operated mental health or DD facility, or in a more restrictive environment. They are identified as those

who require greater support in order to find in-state providers willing to serve them. These individuals' needs outweigh the resources provided within the current waiver rate structure."

- P. 301

  "Analysis was conducted to use Supports Intensity Scale® (SIS®) assessment data to create 'tiered' rates for residential and day habilitation services to recognize the need for more intensive staffing for individuals with more significant needs. Specifically, each member is assigned to one of seven levels based on assessment results in the areas of home living support needs, community living support needs, health and safety needs, medically-related support needs, and behaviorally-related support needs. These seven levels, in turn, are cross-walked to four rate categories: low needs (level 1), modest needs (level 2), moderate to significant needs (levels 3 and 4), and highest needs (levels 5, 6, and 7)."

Outdated references can be found in the following locations in the Building Independence Waiver VA.0430.R04.00 - Jul 01, 2023:

- P. 236

  "Analysis was conducted to use Supports Intensity Scale® (SIS®) assessment data to create 'tiered' rates for residential and day habilitation services to recognize the need for more intensive staffing for individuals with more significant needs. Specifically, each member is assigned to one of seven levels based on assessment results in the areas of home living support needs, community living support needs, health and safety needs, medically-related support needs, and behaviorally-related support needs. These seven levels, in turn, are cross-walked to four rate categories: low needs (level 1), modest needs (level 2), moderate to significant needs (levels 3 and 4), and highest needs (levels 5, 6, and 7."

Appendix C: Suggested Statue Changes

Below we propose changes to the language in current administrative codes 12VAC30 122-20 Definitions[52], 12VAC30-122-200[53], and12VAC30-122-210[54] and . Additions are shown in blue and deletions are ~~stricken through~~ and shown in red.

Language in 12VAC30-122-210 should be modified as such:

Four reimbursement tiers for providers shall be based on six or seven levels of support for adults and seven ~~-~~levels of support for children (as detailed in 12VAC30-122-200) from resultant scores of the SIS®, the responses to the Virginia Supplemental Questions, and, as needed, a document review verification process. The DMAS designee shall verify the scores and levels of the individuals, as appropriate.

a. Levels of supports range from Level 1 to Level 7 for children and Level 1 to Level 7 for adults who have completed the SIS-A® or Level 1 to Level 6 for adults who have completed the SIS-A® 2nd Edition ~~based on the needs of the individuals~~.

b. Tiers of reimbursement:

(1) Tier 1 shall be used for ~~individuals~~ adults and children having Level 1 support needs.

(2) Tier 2 shall be used for ~~individuals~~adults and children having Level 2 support needs.

(3) Tier 3 shall be used for ~~individuals~~adults having either Level 3 or Level 4 support needs if they have completed the SIS-A® and Level 3 or Level 4 support needs if they have completed the SIS-A® 2nd Edition and for children having either Level 3 or Level 4 support needs.

(4) Tier 4 shall be used for ~~individuals~~adults having either Level 5, Level 6, or Level 7 support needs if they have completed the SIS-A® or Level 4, Level M, and Level B if they have completed the SIS-A® 2nd Edition, and for children or adults having either Level 5, Level M, or Level B support needs.

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[52] https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/section20/#:~:text=%22Face%2Dto%2Dface%20contact,for%20additional%20services%20and%20supports

[53] https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/section200/

[54] https://dbhds.virginia.gov/wp-content/uploads/2023/05/DBHDS-SIS%C2%AE-Standard-Operating-Procedures-and-Review-Process-4.28.2023.pdf

Language in 12VAC30 122-20 Definitions should be modified as such:

"Levels of support" means the level (1-7 for children using the SIS-C and adults using the SIS-A and 1-4, M & B for adults using the SIS-A 2nd Edition) that is assigned to an individual based on the SIS® score, the results of the Virginia Supplemental Questions, and, as needed, a supporting document review verification process.

Language in 12VAC30-122-200 should be modified as such:

A. The Supports Intensity Scale (SIS®) requirements.

1. The SIS® is an assessment tool that identifies the practical supports required by individuals to live successfully in their communities. DBHDS shall use the SIS® Children's Version™ (SIS-C™) for individuals who are five years through 15 years of age. DBHDS shall use the SIS® Adult Version® (SIS-A®®) for individuals who are 16 years of age and older. Individuals who are younger than five years of age shall be assessed using an age-appropriate standardized living skills assessment.

4. Scores from SIS-A® and SIS-C™® Section 1 (Exceptional Medical Needs, Exceptional Behavioral Needs), Section 2 Subsections A, B, and E, and responses to Supplemental Questions shall be used to assign levels of supports (Levels 1 through 7, as defined in 12VAC30-122-250) to each individual. Scores from SIS-A® 2nd Edition Section 1 (Exceptional Medical Needs, Exceptional Behavioral Needs), Section 2, and responses to Supplemental Questions shall be used to assign levels of supports (Levels 1 through 4, M, and B as defined in 12VAC30-122-250) to each individual.

B. The current version of the Virginia Supplemental Questions (VSQ ~~version 10/2017~~) shall also be used to identify individuals who have unique needs falling outside of the needs identifiable by the SIS® instrument. The VSQ shall also be administered and analyzed by the same qualified, trained interviewers designated by DBHDS.

1. The Virginia Supplemental Questions shall address these topics:

a. Medical Support Need

b. Behavioral Support Needs ~~Severe medical risk;~~

~~b. Severe community safety risk for people with a related legal conviction;~~

~~c. Severe community safety risk for people with no related legal conviction;~~

~~d. Severe risk of harm to self; and~~

~~e. Fall risk.~~

2. Specified affirmative responses to the items in subdivisions B 1 a through B 1 d of this section shall require a review of the individual's record for verification. After such review, the individual may or may not be assigned to Level 6 (exceptional medical) for children or adults who have completed a SIS-A® or Level M (exceptional medical) for adults who have completed a SIS-A 2nd Edition or Level 7 (exceptional behavioral) for children or adults who have completed a SIS-A® or Level B (exceptional behavioral) for adults who have completed a SIS-A 2nd Edition