Quarterly Policy Committee

July 20, 2026

Today’s Agenda

- Waiver Modernization
  - interRAI
  - Acuity-Based Rates
- Provider Certification: Workgroup & Recommendations
- The Path Forward: Policy Windows

Waiver Modernization

- Disclaimers:
  - Based on what we know and understand as of this moment in time
  - You'll have questions we won't have answers to
  - We'll go through it once, come back for questions/discussion

interRAI Rollout

- interRAI
  - 829 assessments completed as of 6/26/26
  - Additional 982 assessments initiated as of 6/26/26
  - Continue to phase in assessments based on services and waivers
  - Anyone enrolled 7/1/27 and beyond will have interRAI only (no DDP/AAI)
- Concerns:
  - One budget
  - AAI
  - Due process
  - Transition plan/phase in of “support levels”

interRAI: From Assessment to Grouping

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Illustrative Example

Example of support level grouping development using illustrative data and the steps outlined on previous slide.

#1 interRAI Case Mix Inputs (CMGDD and CMI)

#2 Define OH Experience Data

#3 Validate Case-Mix Index

#4 Define Clustering

#5 Define Variances

Case Mix Groups	Standard CMI	Mocked up OH data		Group	Difference from Group
CMGDD	CMI	Average Cost			
FOC	0.45	$	45,427.18	1	$ (19,372.00)
F3A	0.61	$	62,426.86	1	$ (2,372.32)
FOB	0.73	$	72,204.64	1	$ 7,405.46
FOA	0.74	$	79,138.04	1	$ 14,338.85
F3B	0.76	$	68,881.79	2	$ (11,338.18)
F6J	0.76	$	81,898.35	2	$ 1,678.38
F5F	0.77	$	79,330.44	2	$ (889.53)
F3D	0.89	$	90,769.31	2	$ 10,549.33
F3C	0.91	$	100,367.35	3	$ 2,973.00
F5E	0.91	$	83,478.58	3	$ (13,915.77)
F6K	0.93	$	88,027.05	3	$ (9,367.30)
F6I	0.99	$	100,417.97	3	$ 3,023.62
F6G	1	$	107,800.37	3	$ 10,406.02
F5C	1.02	$	104,274.78	3	$ 6,880.43
F9F	1.06	$	109,617.03	4	$ (3,780.08)
F6D	1.13	$	103,923.98	4	$ (9,473.13)
F6E	1.15	$	114,850.38	4	$ 1,453.26
F5D	1.21	$	120,076.66	4	$ 6,679.55
F5B	1.23	$	114,465.89	4	$ 1,068.78
F9C	1.23	$	117,448.74	4	$ 4,051.62
F5G	1.24	$	130,701.97	5	$ 4,314.08
F3E	1.25	$	124,776.44	5	$ (1,611.45)
F6B	1.26	$	121,101.97	5	$ (5,285.92)
F9E	1.31	$	120,533.01	5	$ (5,854.88)
F9G	1.34	$	124,267.56	5	$ (2,120.33)
F6C	1.37	$	126,897.38	5	$ 509.49
F9D	1.37	$	130,250.33	5	$ 3,862.44
F6H	1.45	$	132,574.46	5	$ 6,186.57
F6F	1.5	$	149,930.38	6	$ (6,031.86)
F9B	1.52	$	146,575.02	6	$ (9,387.22)
F9A	1.6	$	158,522.91	6	$ 2,560.67
F5A	1.69	$	155,357.44	6	$ (604.81)
F6A	1.79	$	169,425.47	6	$ 13,463.22
r^2	97%				

Group	Group Average
1	$ 64,799
2	$ 80,220
3	$ 97,394
4	$ 113,397
5	$ 126,388
6	$ 155,962

From interRAI Sample to CMG

1,000 Person Sample

- Determines average (1)
- Determines "range" (above/below average) – in the example it's .45 to 1.79

33 Case Mix Groups

•Based on their **Case Mix Index** (CMI = "score" on interRAI - how much above/below average), people assigned to one 33 **Case Mix Groups** (CMGDD) – these are "standard"
•If spread were exactly even, with 1,000 people, there'd be about 30 people in each CMG

Case Mix Groups	Standard CMI
CMGDD	CMI
FOC	0.45
F3A	0.61
FOB	0.73
FOA	0.74
F3B	0.76
F6J	0.76
F5F	0.77
F3D	0.89
F3C	0.91
F5E	0.91
F6K	0.93
F6I	0.99
F6G	1
F5C	1.02
F9F	1.06
F6D	1.13
F6E	1.15
F5D	1.21
F5B	1.23
F9C	1.23
F5G	1.24
F3E	1.25
F6B	1.26
F9E	1.31
F9G	1.34
F6C	1.37
F9D	1.37
F6H	1.45
F6F	1.5
F9B	1.52
F9A	1.6
F5A	1.69
F6A	1.79

From CMG to Support Level

33 CMGDD + Historical Utilization

- Utilization
- PAWS
- Validate the CMI (range/spread)

Group

- DODD is calling this "**Support Level**"
- Exact # of Support Levels to be determined (validation, variances) – in the example, it's 6

Case Mix Groups	Standard CMI	Mocked up OH data	Group
CMGDD	CMI	Average Cost	
FOC	0.45	$ 45,427.18	1
F3A	0.61	$ 62,426.86	1
FOB	0.73	$ 72,204.64	1
FOA	0.74	$ 79,138.04	1
F3B	0.76	$ 68,881.79	2
F6J	0.76	$ 81,898.35	2
F5F	0.77	$ 79,330.44	2
F3D	0.89	$ 90,769.31	2
F3C	0.91	$ 100,367.35	3
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F6K	0.93	$ 88,027.05	3
F6I	0.99	$ 100,417.97	3
F6G	1	$ 107,800.37	3
F5C	1.02	$ 104,274.78	3
F9F	1.06	$ 109,617.03	4
F6D	1.13	$ 103,923.98	4
F6E	1.15	$ 114,850.38	4
F5D	1.21	$ 120,076.66	4
F5B	1.23	$ 114,465.89	4
F9C	1.23	$ 117,448.74	4
F5G	1.24	$ 130,701.97	5
F3E	1.25	$ 124,776.44	5
F6B	1.26	$ 121,101.97	5
F9E	1.31	$ 120,533.01	5
F9G	1.34	$ 124,267.56	5
F6C	1.37	$ 126,897.38	5
F9D	1.37	$ 130,250.33	5
F6H	1.45	$ 132,574.46	5
F6F	1.5	$ 149,930.38	6
F9B	1.52	$ 146,575.02	6
F9A	1.6	$ 158,522.91	6
F5A	1.69	$ 155,357.44	6
F6A	1.79	$ 169,425.47	6

r^2 97%

From Support Level to Budgets, Bands, Tiers

Group (Support Level)

- **Budget**: They compare this to DDP "funding range" – unclear if/how this will work (one budget, range, etc.)
- **Service Band**: Recommended range of support hours common to people in the group (per week, per month)
- **Acuity-based reimbursement tier**: May vary depending on service

Group	Group Average
1	$ 64,799
2	$ 80,220
3	$ 97,394
4	$ 113,397
5	$ 126,388
6	$ 155,962

From Tiers to Rates/Reimbursement

- DODD's focus has been MRC
  - Initially: "fixing"/improving or replacing
  - Current: replacing ("CMS won't allow")
    - 15-minute units (current model; acuity-based staffing model; acuity-based staffing + home-size model)
    - Daily rate (partial day, day, overnight)
- Common question: "do providers want to get paid for exactly what they're delivering OR do they want simplicity in billing?"
- For today's purposes pretend EVV is "off the table" (happens no matter what)
- Let's not forget FWA
- Concerns:
  - Verification of what CMS will/won't allow
  - False choice, complexity
  - No modeling w/real costs, real people (assumptions about who lives together, what people do during the day)
  - No information on budgets (one budget)

Acuity-Based Rates

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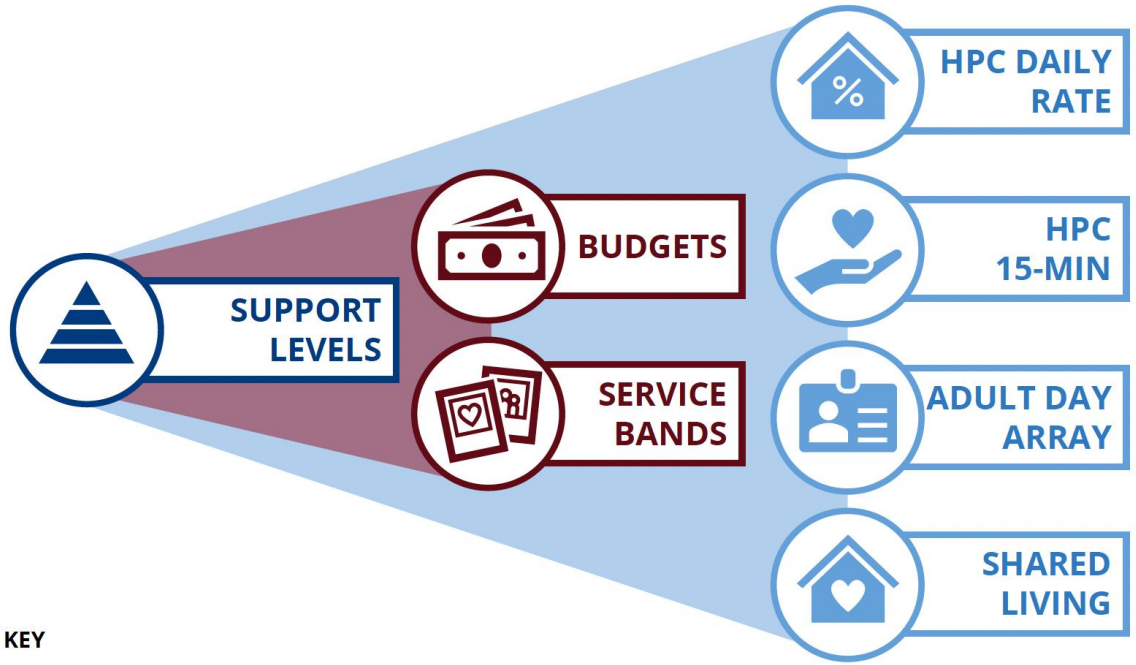
Acuity Model Structure

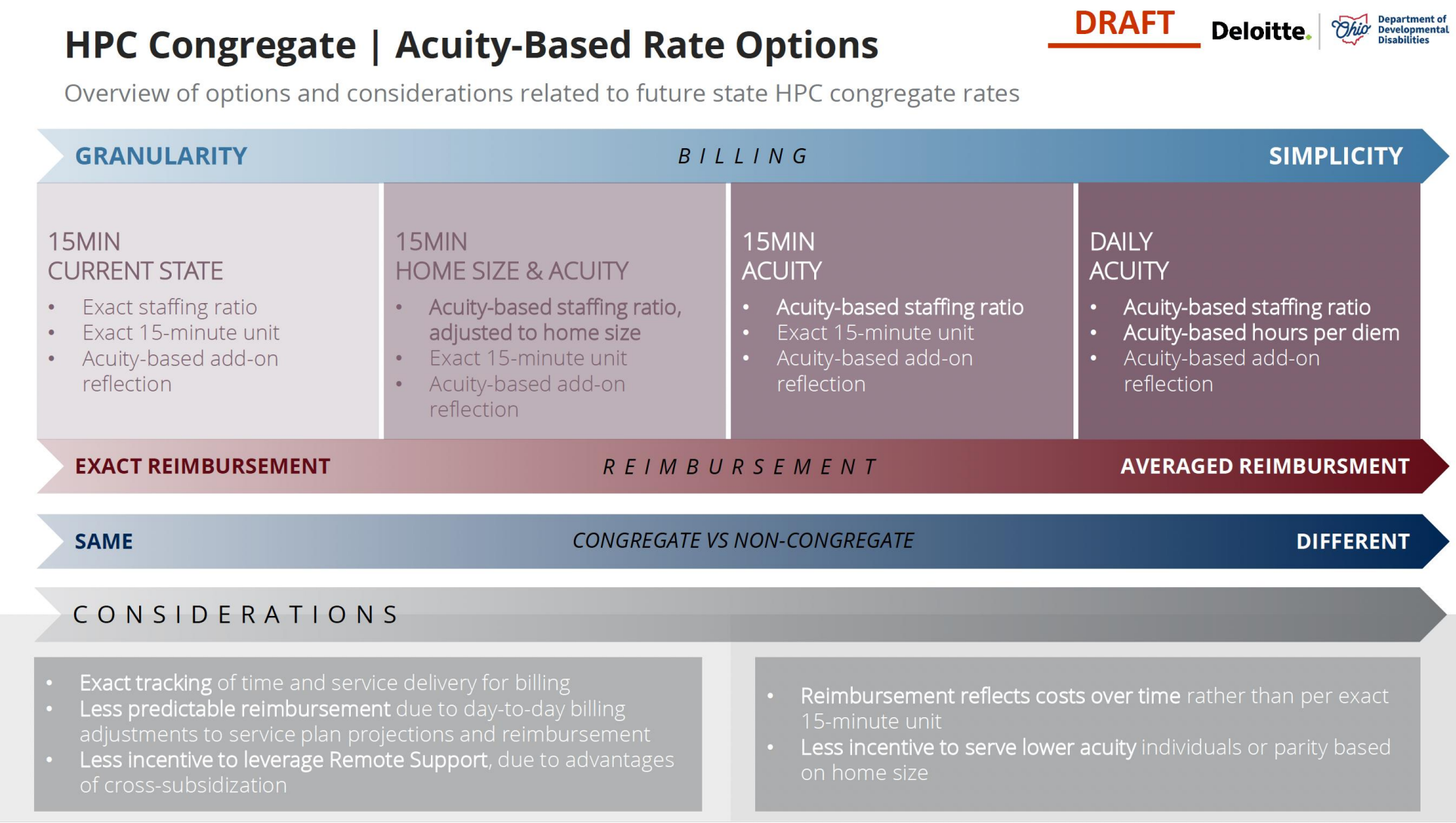
Aligning on high level structure of anticipated future state acuity tiers and how they inform programmatic acuity-based components



ACUITY STRUCTURE

- interRAI-based **support levels** serve as the basis for all other acuity-informed programmatic components: service allocation management and acuity-based rates
- **Service allocation management** includes I/O budget and service bands, where the corresponding recommended service sets and costs of acuity-based services inform overarching budget projections
- Since different services have varying natures of delivery, **interRAI-based support levels** may be grouped into service-specific **acuity reimbursement tiers**

HPC Congregate



15 Minute Current State (Granularity)

[redacted] | Current State

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Outline of option to keep the current staffing ratio model that exists today, but incorporating acuity into fee schedule rates

CURRENT STATE

ACUITY ADJUSTED

Acuity assumption limited to additional staff specialization needs to serve person. **Staffing lives completely outside of the rate** and is captured in the number of **people that are being served by 15-min unit.**

Provider bills the rate for **each person** based on their acuity tier and number of people receiving the service.

EXAMPLE RATE TABLE

Acuity Tier	Staffing Ratio			
	1:1	1:2	1:3	1:4+
1	$$	$	$	$
2	$$	$	$	$
3	$$	$$	$	$

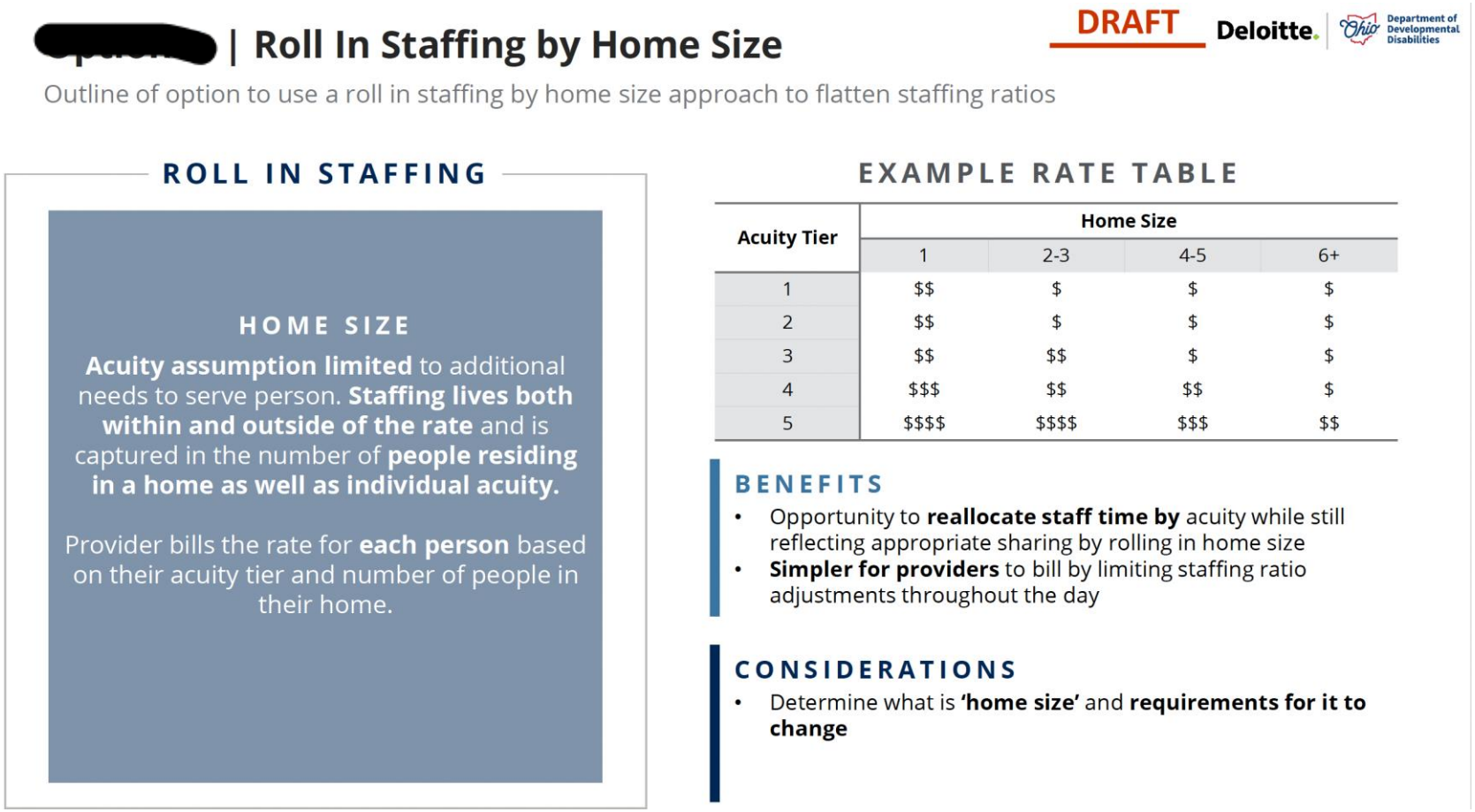
BENEFITS

- **Exact reimbursement** for services delivered
- **Simpler transition** from current state billing practices and **same application to non-congregate billing**

CONSIDERATIONS

- Time tracking and **billing complexity**
- **Fluctuation in rate billed** throughout the day and throughout the year

15 Minute Home Size & Acuity



[redacted] | Roll In Staffing by Home Size

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Outline of option to use a roll in staffing by home size approach to flatten staffing ratios

ROLL IN STAFFING

HOME SIZE

Acuity assumption limited to additional needs to serve person. **Staffing lives both within and outside of the rate** and is captured in the number of **people residing in a home as well as individual acuity.**

Provider bills the rate for **each person** based on their acuity tier and number of people in their home.

EXAMPLE RATE TABLE

Acuity Tier	Home Size			
	1	2-3	4-5	6+
1	$$	$	$	$
2	$$	$	$	$
3	$$	$$	$	$
4	$$$	$$	$$	$
5	$$$$	$$$$	$$$	$$

BENEFITS

- Opportunity to **reallocate staff time by** acuity while still reflecting appropriate sharing by rolling in home size
- **Simpler for providers** to bill by limiting staffing ratio adjustments throughout the day

CONSIDERATIONS

- Determine what is **'home size'** and **requirements for it to change**

15 Minute Acuity

[redacted] | Roll In Staffing by Acuity

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Outline of option to use a roll in staffing by acuity approach to flatten staffing ratios

ROLL IN STAFFING

IN ACUITY

Acuity assumption includes additional needs to serve person and assumed staffing ratio. **Staffing assumptions** are **built** into acuity tiers.

Provider bills the rate for **each person** based on their acuity tier.

EXAMPLE RATE TABLE

Acuity Tier	Staffing Assumption	Rate
1	Mostly Shared	$
2	Mostly Shared	$$
3	Some Alone	$$$
4	More Alone	$$$$
5	Mostly Alone	$$$$$

BENEFITS

- **Aligns** payment more directly to **expected support** intensity
- **Simplifies** rate structure by **reducing staffing-specific code** variation
- Creates a **clear link** between **acuity** and **reimbursement**

CONSIDERATIONS

- **Providers** who serve people with lower acuity who live in smaller homes may experience greater impacts

Daily Acuity

Acuity-Based Daily Rate Model Components | Overview

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Breaking down the different components of the proposed approach and highlighting

APPROACH COMPONENT	DECRIPTION & REASONING	END GOAL
1 ACUITY-BASED DAILY RATE	• **Streamlined rate model** and reimbursement for individuals of like needs that aligns to CMS expectations • **Limit volatility** from roommate schedules and services • Shift away from **splitting costs** for budget purposes	• Focus service planning discussions on **hours rather than dollars** • Create a **consistent reimbursement structures** for providers
2 SEPARATE NIGHT BILLING	• Focus overnight support **needs on health & safety** • Shift away from **splitting overnight costs** for budget purposes • **Increase accuracy** during the day	• **Focus OSOC delivery** for those who may need it • **Incentivize Remote Support** • Enhance **provider capacity**
3 PARTIAL RATES	• Reflect hours that may **not meet full day service minimums** • Limit instances of **billing the 15-minute unit** • Provide a **lower-hour alternative** for high acuity individuals to attend **day programs**	• Reflect **time-served more accurately** • Leverage in **service planning meetings** to **project time**
4 THERAPEUTIC LEAVE DAYS	• Reflect current billing processes & **limit change** • Establish maximum to **align with CMS guidance and approval**	• Create a **smoother transition** • Cover portion of **costs to maintain staff** • **Alleviate impact** to projected revenue

DODD Questions (Hold that thought…)

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Feedback Discussion Questions

Outlining key discussion questions to navigate and drive decision making related to HPC congregate acuity-based rate options

1. **Which option aligns best with current practices for time tracking and service delivery documentation?**
   Consider options that feel like an extension or re-application of current processes rather than those that create net new or additional documentation needs and processes
2. **Which option are you most comfortable with when it comes to a reflection of staff time?**
   Consider options that reflect the level of detail you expect and would hope for in a given reimbursement rate as it relates to staff time delivered
3. **Which option are you most comfortable with when it comes to reflection of individual need?**
   Consider options that allow service rendered to be accurately and appropriately based on the individuals that need them and the options that simplify this acuity-based allocation
4. **Which option creates the least administrative burden?**
   Consider options that ease oversight of billing, verification that services billed match services rendered, and adjustments to service plan and staff scheduling
5. **Which option best translates into future state?**
   Consider options that align best to how you envision future state given the current CMS environment, transition from MRC, and translation from how rates are billed today
6. **Which of the above considerations are most important to you and the stakeholders you represent?**

OPRA Asks (Current Admin or Lame Duck)

Assessment

- Establish **interRAI as the single statewide assessment instrument** used to determine assessed need.
- Prohibit the use of additional local assessment tools by county boards to establish support levels, service bands, or individual budgets.

Budgets

- Clearly explain how existing budgets will be incorporated into the unified individual budget.
- Validate the new budgeting methodology through fiscal and operational modeling before implementation, including its impact on individuals' budgets, provider operations, and **system sustainability**.
- During the transition period, **maintain budget neutrality** for individuals receiving services unless changes are driven by the person-centered planning process.
- Ensure individuals **do not lose access to existing ser**vices solely because of the transition to a new budgeting methodology.
- Allow sufficient time for providers, county boards, and individuals to **adapt before budget changes take effect**.

OPRA Asks (Current Admin or Lame Duck)

Person Centered Planning

- Preserve person-centered planning as the mechanism for determining authorized services.
- Clarify that assessment results and support levels inform—but do not replace—individualized planning.
- Ensure flexibility to address individual circumstances not fully reflected in the assessment.

Due Process

- The transition itself cannot eliminate due process simply because every individual's budget and support level are being recalculated under a new methodology.
- Clearly establish appeal rights related to:
  - assessment results,
  - support level assignments,
  - service bands,
  - individual budgets,
  - and authorized services.
- Define what constitutes an appealable action within the new framework.
- Ensure individuals have meaningful notice explaining how decisions were made and how to challenge them.

OPRA Asks (Current Admin or Lame Duck)

Transparency & Accountability

- Establish measurable implementation metrics and publicly report progress throughout the transition.
- Regularly monitor and report:
  - **Access to services**, including authorization trends, PAWS data, claims utilization, and service availability.
  - **Budget impacts**, including comparisons between individuals' current combined service utilization and proposed unified budgets.
  - **Appeals, exceptions, and administrative reviews**, including trends and outcomes that may indicate systemic issues.
  - **Implementation issues**, including system defects, operational challenges, and corrective actions taken.
- Use implementation data to make policy and operational adjustments before advancing to subsequent phases of payment reform.

Future Payment Reform

- Develop a long-term roadmap toward payment models that:
  - reflect assessed acuity and complexity,
  - reward quality and outcomes,
  - support innovation,
  - maintain provider network adequacy,
  - and are fiscally sustainable.
- Evaluate the role of selective contracting, value-based purchasing, cost reporting, and other alternative payment approaches through a transparent stakeholder process before implementation.

Provider Certification: Recommendations

Clarification & Clean Up

- Better organization of rule, improved definitions, consistency
- Consolidate training requirements in appendices, allow for department-approved
- Reminder of scope (Medicaid and non-Medicaid)

Bigger Changes

- Stronger pre-application training requirements for DOOs
- Provisional certification period (one-year)
- Ongoing demonstration of financial viability

Provider Certification: Watching

- Unrelated guardians
- Inducements
- Duplication/inconsistencies with other rules
- What providers can/can’t do

The Path Forward

Policy Windows

- Current Administration
- Lame Duck
- Transition Teams
- New Administration
- SFY 28-29 Budget
- SFY 30-31 Budget

Current Administration

- **Goal**: Advance the future state through administrative action while laying the foundation for long-term transformation.
  - County Board Regionalization (authority/money?)
  - Specialized Services (e.g., ICF vent beds, DC plan for youth)
  - Provider Cert Rule
  - interRAI & acuity-based rates
  - Budget development

Lame Duck

- **Goal**: Remove barriers, lay the foundation for future reforms.
  - Community Capital Assistance
  - Settings Rule (statewide use of ODM tool, definitions)
  - Lift/modify bed moratorium (specialized populations)
  - Transportation (DOT physical)
  - interRAI “protections” (single assessment, due process, transition period)
  - Statewide Needs Assessment (now and tied to SB 315 waiver study)
  - ODM/DODD/MCO Quality Improvement Project (“fatal five” or other outcomes)

Transition Team

- **Goal**: Shape the agenda of the next administration.
  - Present OPRA's vision for the future system
  - Recommend leadership priorities and system leaders
  - Introduce modernization plan
  - Build support for statewide, coordinated, payment reform, and continuum development
  - **BE READY**: to lead/influence transition to managed care

New Administration (First 100 Days)

- **Goal**: Shape the Governor's proposed budget by demonstrating the value of prior investments and advancing the next phase of system modernization.
  - Meet with agency leadership and budget staff
  - Demonstrate the impact of prior rate investments
  - Make the case against rate cuts or rollbacks
  - Advocate for OPRA's modernization priorities for inclusion in the Governor's budget
  - Recommend policy language and strategic investments that build toward the future state

SFY 28-29 Budget

- **Goal**: Protect existing investments while securing the policies, funding, and authority needed to begin transformation.
  - Preserve prior rate investments and protect against funding cuts
  - Include priority policy language and appropriations
  - Invest in statewide infrastructure (assessment, data, quality, technology)
  - Begin building the continuum of care and specialized capacity
  - Establish authority for new payment methodologies or demonstration projects
  - Protect key provisions throughout the House and Senate process

SFY 30-31 Budget

- **Goal**: Expand and sustain the transformation by building on proven results.
  - Demonstrate the outcomes of previous investments
  - Expand successful payment reforms and specialized services
  - Continue investments in workforce, technology, and quality improvement
  - Advance additional administrative simplification and risk-based oversight
  - Complete structural reforms that require phased implementation (e.g., payment reform)