REPORT OF THE
SECRETARY OF HUMAN
RESOURCES OF THE

Feasibility and Cost-Effectiveness of Applying for a Medicaid Waiver for Case Management

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 39

COMMONWEALTH OF VIRGINIA
RICHMOND
November 15, 1983

TABLE OF CONTENTS

FOR HJR 77 REPORT

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TO: The Honorable Charles S. Robb, Governor of Virginia
and
The General Assembly of Virginia

I. INTRODUCTION

The 1983 General Assembly by House Joint Resolution No. 77 requested the Secretary of Human Resources to establish a joint Task Force of the Departments of Health and Mental Health and Mental Retardation to study the feasibility and cost effectiveness of applying for a Medicaid waiver for case management services. The resolution is as follows:

House Joint Resolution 77

WHEREAS, the Department of Mental Health and Mental Retardation is mandated to perform case management services; and

WHEREAS, a number of our sister states have applied for a Medicaid waiver under Section 2176 of P.L. 97-35, the Omnibus Budget Reconciliation Act of 1982, for case management in order to increase funds available for case management without increasing state appropriations; and

WHEREAS, the Department of Health is the duly authorized representative in the Commonwealth to receive Medicaid funds; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, that the Secretary of Human Resources is requested to establish a joint task force of the Departments of Health and Mental Health and Mental Retardation to study the feasibility and cost-effectiveness of applying for a Medicaid waiver for case management from the United States Department of Health and Human Services. The Secretary of Human Resources is requested to report the task force's recommendations to the 1984 Session of the General Assembly.

II. EXECUTIVE SUMMARY

The 1982 session of the General Assembly directed the Secretary of Human Resources to conduct a feasibility and cost effectiveness study of applying for Medicaid Wavier for case management for the mentally retarded. This analysis has concluded that a Federal Medicaid Waiver for case management is not cost effective for the Commonwealth or its localities. Financial analaysis indicates the potential cost savings in State and local funds through federal Medicaid participation in the cost of waivered case management services are more than offset by requirements for additional local case management staff and by the need for expanded community-based services for the clients who would be eligible for waivered services.

The report recommends the Departments of Health and Mental Health and Mental Retardation complete the development of a waiver for an array of community-based services, including case management, which are necessary to support a mentally retarded person in the community at less cost than institutional care. This application for a waiver for an array of community-based services will be developed by July 1, 1984 for implementation during the 1984-86 biennium. Medicaid funding in the amount of $2 million to initiate this comprehensive waiver approach will be available from projected medicaid savings in the Department of Mental Health and Mental Retardation budget due to projected geriatric center medicaid cost reductions.

III. TASK FORCE COMPOSITION AND RESPONSIBILITIES

The Secretary of Human Resources established a Joint Task Force composed of representatives of the Department of Health, the Department of Mental Health and

Mental Retardation and the Department of Social Services. In view of the fact that an interdepartmental working group of the Departments of Health and Mental Health and Mental Retardation had been in the process of waiver development for several months, the HJR 77 study was made a part of the on-going waiver development. In addition, the representatives from the Department of Social Services were added to the Task Force membership because of that agency's responsibility to promote and administer many community based care programs to similar populations. (See Appendix A)

IV. HISTORY

A. The Commonwealth's Commitment to Community Services

1. The Governor's Guidance for 1984-1986: Among the Goals and Objectives included in the Governor's Guidance for 1984-1986 was the Goal to reduce costs by developing home and community-based care to substitute in part for the expensive institutional care. Three objectives were outlined to achieve this goal. Among them was to improve the Commonwealth's capacity to aid people in their homes and neighborhoods and expand outpatient services to enable people to stay at home or in their community in lieu of expensive institutional placements.

2. The Commission on Mental Health and Mental Retardation (House Document No. 8), chaired by Delegate Richard Bagley, current Chairman of the Appropriations Committee of the House of Delegates of the General Assembly of Virginia, declared a general policy of fostering "high quality services and care for mentally handicapped citizens...The policy calls for a coordinated system of statewide services providing treatment, training and care in the least restrictive environment possible...A fundamental element in adhering to the principles of the declaration of policy is a system of case management."

3. The 1983 House Appropriation Act relating to Chapter 10 of Title 37.1 of the Code of Virginia, states that "the intent of the General Assembly in operating the array of community residential facilities...is that the cost

of treating a person in a community facility should be less than the cost of treatment in an institutional setting when considering the cost per patient day and length of stay."

4. Seeking a waiver for support of community-based care and training of mentally disabled persons is consistent with the recommendation of the Commissioner's Task Force on Core Services, Formula Funding, and Facility Census Reduction. The Task Force recommended that the Commissioner of Mental Health and Mental Retardation study "approaches to building a single system of services that (i) preserves the capacity of the State to provide institutional services until no longer needed, (ii) facilitates local management of services, (iii) assures stability of funding for facilities, and (iv) offers appropriate incentives for development of local alternatives to facility use."

   The waiver, with a full array of services, could meet all of the aforementioned policy objectives, if community alternatives are less expensive than institutional care. Also, training must be supplied in greater measure than is now available if utilization of high cost state-operated facilities by many communities throughout Virginia is to be curtailed. Very often compromise on the provision of care and training in the least restrictive environment occurs because of the lack of a community alternative to institutional placement. An array of services under the waiver could assist implementation of an orderly transition from high reliance on institutional care and training provisions to community-based alternatives. If carefully designed, these community-based alternatives will be less expensive than current institutional services, which tend to create dependency, i.e., longer lengths of stay than necessary and sometimes inappropriate institutional placements--all of which translate into higher than necessary expenditures of state and federal funds.

B. Summary of Medicaid Coverage

In 1972, in Virginia, Medicaid coverage was extended to care in intermediate care facilities, including institutions for the mentally retarded. For the first time Federal funding was extended to services formerly purchased by limited

state dollars alone. In 1972, the long process was begun to improve the physical facilities, staffing and programs of the institutions for the mentally retarded operated by the Department of Mental Health and Mental Retardation. Over the next decade vast improvements were made such that in 1983 all state-operated mental retardation facilities are certified for participation in Medicaid. During this time, the number of mental retardation certified beds grew from 2159 in 1973 to 3755 in 1983, while Medicaid expenditures for these facilities grew from $10,035,000 to $84,332,921.

Prior to passage of the Omnibus Budget Reconciliation Act of 1981, the Medicaid program provided little coverage for long-term care services in a noninstitutional setting. Non-institutional services were limited, for the most part, to traditional primary care services such as hospital, physician, pharmacy and laboratory services. These services fell far short of meeting the needs of the mentally retarded who required supervised living and habilitation services. Although Medicaid could pay for these when rendered in an institutional setting, in-home services were non-existent.

Because the needs were great, greater numbers of mentally retarded citizens were placed in institutions until, crowded to capacity, long waiting lists developed. Families, discouraged by the slow growth of services for the mentally retarded in their communities, often sought institutional placement for their children only because it provided the sole access to much needed services.

Because of the structure of Title XIX of the Social Security Act, there was a Medicaid eligibility bias toward institutional care. Federal regulations for eligibility of Medicaid required that an alternate budgeting scale be used to determine eligibility when a person entered an institution. Because of this provision, individuals who were ineligible for Medicaid while living at home became eligible as soon as they were admitted to the institution.

Another barrier to Medicaid payment for in-home services was the fact that Medicaid is an entitlement program. Entitlement means that every eligible individual must be provided every covered service he needs, in the same

amount, duration, and scope as any other recipient. There was the possibility that if Medicaid paid for any additional in-home services, the Program would be flooded with so many eligible clients that there would be insufficient funds in the budget. The fear was that the State would find that it was still covering all the institutional clients it had previously, plus an additional population at home. All states faced this dilemma. This is the motive behind the waiver provision of the Omnibus Budget Reconciliation Act in 1981.

C. Medicaid Home and Community Based Care Waivers

Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981, conferred upon the Secretary of Health and Human Services the authority to waive certain Medicaid statutory limitations to enable a state to cover a broad array of home and community-based services to individuals who, without these services, would have to enter an institution. A state could receive such a waiver if it provided certain assurances to the Secretary:

1. That the State would impose certain safeguards to protect the health and welfare of recipients who received services under the waiver;

2. That the State would assure financial accountability for funds spent for the services;
3. That the State would provide for an evaluation of the need for inpatient services for individuals who require a skilled or intermediate level of care;

4. That any individual determined to need a skilled or intermediate level of care will be informed of the alternative services available under the waiver and given a choice to receive in-patient or alternative non-institutional services;

5. That the average per capita expenditure estimated by the State for Medicaid provided to these individuals will not exceed the average per

capita expenditure that the State estimates would have been made for these individuals under the State Plan if the waiver had not been approved;

6. That the State will provide, annually, information on the impact of the waiver on the type and amount of Medicaid provided and on the health and welfare of its recipients.

A state may be granted authority to provide the following services:

1. Case management services
2. Homemaker services
3. Home Health Aide services
4. Personal care services
5. Adult day health services
6. Habilitation services
7. Respite care services
8. Other services requested by the State and approved by the Secretary.

States were given the latitude to define these services which are only generally discussed in the October 1981, "Federal Register." However, as provided in statute, none of these services could include costs or charges for room and board. In addition, the law provided that a state could be granted waivers of the requirements of section 1902 (a) (1) and (10) of the Social Security Act. The first of these required that services under the Plan must be in effect throughout the state. The second set forth requirements that services available to the categorically needy recipient are not less in amount, duration, and scope than services available to the medically needy and are equal in amount, duration, and scope for all categorically needy recipients. It was precisely these "entitlement" provisions that had previously prohibited Medicaid coverage because expenditures under the program could not be controlled. The waiver of these requirements permitted the state to control access to the services, to the funds available and to specifically targeted

groups of people. Thus, Medicaid waivers allow flexibility and creativity in development and coverage of new or different services; however, waivers also have limitations based on law which a state must meet in order to receive waiver approval.

V. ADVANTAGES AND DISADVANTAGES OF WAIVERS

Existing Opportunities Which Would Facilitate the Development/Implementation of a Community Waiver

Over the last decade public expenditures on behalf of persons with mental disabilities have increased substantially. This increased spending has resulted from two major factors; the transformation of large overcrowded and primarily custodial state facilities into smaller physically improved and more intensive treatment environments and the development of more community-based alternatives to institutional care. Institutional reform and building of service in the community has greatly benefited large numbers of mentally handicapped individuals and their families. At the same time, however, the enormous cost of maintaining two major services within our system has become increasingly difficult to justify, particularly in times of intense competition for human service resources. As community-based programs increase their capacity to provide services to the most handicapped persons, the use of state operated institutions and other longterm care facilities will be reserved for smaller, more homogenous groups of clients. Identification of the optimal strategy for returning inappropriately institutionalized persons to the community and preventing equally inappropriate institutionalization in the future is a challenge for mental health/mental retardation administrators.

Medicaid represents by far the largest Federal funding source for Mental Health and Mental Retardation services. It also provides states with the greatest potential to affect meaningful system changes. Medicaid dollars for the development of community-based services may:

1. Afford states an opportunity to reduce dependency on inappropriate and expensive institutional services;

2. Provide an alternative placement in a lesser restrictive environment for disabled persons in institutional settings;

3. Emphasize potential cost savings associated with in-home and other non-institutional services;

4. Allow states greater flexibility in the provision of services to the disabled population, including coverage for certain non-medical services for eligible individuals who would otherwise require institutional services;

5. Facilitate state census reduction plans by encouraging the development of lesser costly non-institutional living and programming alternatives; and

6. Enhance the state's ability to move more rapidly toward a single system.

Barriers/Constraints Which Require Consideration in Assessing the Feasibility of a Waiver

Many states which have applied and have been approved for the Medicaid Waiver Services have identified the following as barriers and constraints which require consideration in assessing the feasibility of a waiver:

1. The intent of the waiver from the federal perspective is to curb future increases in Medicaid costs. States will have to bear any cost overruns due to to the coverage of non-institutional services. There are no new dollars to the system--only a rearrangement of current funds.

2. Although the Department of Mental Health and Mental Retardation and Department of Health are jointly working to develop a waiver, the DMH/MR must compete with other programs or priorities in decisions regarding funding.

3. The financial impact to State facilities can be devastating if not appropriately addressed and planned.

4. There are cost shifts among agencies and between state and local governments. Room and board are not reimbursable services under the waiver. The cost of room and board above the available Supplemental Security Income must be borne by other state and local programs. There must be funding to subsidize the room and board cost.

5. Development of a policy and plan to reduce new admissions will be necessary; otherwise we continue to have a revolving door procedure with no reduction of inpatient population.

6. The inability to predict/project what Medicaid dollars will be available for eligible clients after the waiver period has expired makes long range planning more risky and complex.

VI. CONSIDERATIONS IN PLANNING AND PROGRAM EXPANSION

A. Target Populations

This proposed waiver under study is to allow case management services to a specific target population of mentally retarded individuals. Persons identified as potential participants in the waiver services are listed below; they include those presently residing in one of the State's five mental retardation facilities who may be potential candidates for community care services and those eligible for admission to one of these facilities but whose application is pending.

Community Services Board	Institutional MR Residents Who May Be Potential Clients Of Community Services Programs
Central Va. CSB	155
Fairfax-Falls Church	159
Norfolk	120
Richmond	163
Roanoke Valley	105
Total	702

Facility Current Pending Applications as of September 29, 1983. (Does not include planned facility transfers).

CVTC	0
NVTC	29
SEVTC	18
SVTC	9
SWVTC	26
Total	82
Grand Total	790

The Department of Mental Health and Mental Retardation is designing its waiver program to achieve target efficiency, i.e., to impact on those geographic areas and service populations which are known to cause inappropriate and excessive utilization of mental health and mental retardation facilities. If granted and successfully implemented, long-term savings will accrue to both the federal and state governments by reducing inappropriate and excessive use of institutional services.

The intent of the community waiver is to phase down institutional services while building up community capacity to serve people who would otherwise require placement in an institution. The approach chosen reflects the best estimate of the Department of Mental Health and Mental Retardation on how

much can be undertaken to minimize disruption while building community program capacity. This approach also recognizes the need to reduce the census of institutions in order to meet budget constraints imposed by the Governor and the General Assembly as a consequence of the economic recession in Virginia.

B. Case Management for Services Coordination

Under a 2176 Waiver, Community Service Boards currently offer Case Management for Services Coordination. Case Management consists of a series of activities performed by designated personnel within a Community Services Board area to assist an individual in need of several services to access available resources in the home community. The case management process includes the following functions:

Assessing: to determine the service needs of an individual.

Planning: to formulate a written Individual Services Plan indicating: (a) the service needs, (b) the appropriate agencies, programs, etc. to meet the service needs, (c) the persons responsible for coordinating attainment of the services and (d) the target dates for services attainment.

Linking: to contact and actively facilitate with agencies, programs, individuals, and families, etc., to arrange for the provision of the services as specified in the plan.

Monitoring: an on-going process of reviewing and updating client needs, the Individual Services Plan, and effectiveness of linkages to ensure services were accessed, received, and that the individual's current status is reflected.

Several major elements are essential to the effectiveness of the above process: (a) the identification and referral of individuals in need of Services Coordination, (b) the involvement of the individual and his/her family (where appropriate) in all activities of the process, (c) the need for team partici-

pation at both inter- and intra-agency levels at junctures considered appropriate, (d) the enhancement of the ability of the individual to become integrated into his/her natural/generic support sy tem, and (e) an administrative structure designed to allow maximum benefit to the individual in need of Services Coordination.

C. Assessment Method

The Virginia Department of Mental Health and Mental Retardation will conduct an assessment of each beneficiary and will determine the appropriate level of care through comprehensive objective methodology in order to ascertain if the beneficiary meets the ICF/MR level of care requirements. The assessment/evaluation will be performed by a team of qualified mental retardation professionals at the State Mental Retardation facilities. It is expected that actual determination of the beneficiary's eligibility for community-based services under the waiver would not be a very lengthy process as the population target to be served are already certified as the level of care needed in an ICF/MR. Each assessment/evaluation will be done by an interdisciplinary team consisting of at least a physician, psychologist, and social worker. Other team members are added as needed and may include educators, physical therapists, audiologists, occupational therapists, community services board staff and others as dictated by special needs.

The information for the assessment will be summarized and submitted by mental retardation facilities to the community services board case manager for recommendations for waivered services.

Community services boards will designate a person to make the final decision on who receives waivered services and will provide case management for service coordination as defined in this document.

D. Criteria for Eligibility

In order for a client to be eligible to receive community-based services under the waiver, she/he must:

1. Be eligible for Medical Assistance under State of Virginia regulations as implemented by the Department of Health.

2. Be a current resident of Central Virginia Training Center, Southside Virginia Training Center, Southeastern Virginia Training Center, Northern Virginia Training Center, or Southwestern Virginia Training Center.

3. OR be pre-screened and on the waiting list for admission to the training centers listed in No. 2.

VII. FEASIBILITY AND COST EFFECTIVENESS

Analysis of the feasibility and cost effectiveness of a Medicaid Waiver for case management is developed below. This analysis was based on the following assumption:

Total Medicaid funds allocated to DMH/MR in the Governor's budget target for 1984-86 could not be exceeded.

Total FY 84 case management dollars (non-federal) identified for case management in the five geographic areas are as follows:

CSB Area	Case Management Funding
Central Virginia	$ 146,040
Fairfax-Falls Church	356,024
Roanoke	88,520
Richmond	89,195
Norfolk	60,188
TOTAL	$ 739,967

*The current annual average cost per client for case management services is $418.

Based on analysis of staffing patterns, caseloads, and projected costs in the above CSB areas for FY 86, an estimated annual cost of $500 per client has been projected for case management. As these retarded individuals will require continuous assessment and monitoring activities, it is estimated that a case manager reasonably can handle a caseload of approximately 60 persons, if that caseload is limited to eligible Medicaid waivered clients.

If all of the current institutional MR residents projected for discharge were to be served by CSB staff under a waiver arrangement, the total case management cost is estimated at $361,000 (702 persons x $500 per case). This $361,000 represents a maximum case management costs for the institutionalized MR residents. In addition, the waiting list group of 82 persons would cost $41,000. This combined cost, potentially eligible for Medicaid reimbursement, would total $402,000.

Using the existing Federal/State ratio, a total of $229,140 would be potentially offset by federal dollars. In summary, a maximum of $229,140 of current State/local dollars would become available if a case management waiver was available for this target population. The reasons this $229,140 of available State-local dollars does not provide sufficient financial advantage to the Commonwealth are as follows:

> Existing local case management staff cannot absorb all the proposed waiver-eligible recipients; therefore, additional case managers would have to be hired. The cost of this additional staff would almost equal the entire available savings.
>
> Costs of community care such as habilitation, respite care, transportation, etc. would require new State-local dollars to be put in place. Again, the costs of these needed community services are above the projected case management "savings".

Costs required to meet expanded documentation and administrative requirements are difficult to calculate; however, the State's experience in the Intermediate Care Facilities for the mentally retarded (ICF/MR) program indicate additional costs to meet federal Medicaid requirements.

The Department of Mental Health and Mental Retardation cannot reduce current staffing at its mental retardation facilities to generate Medicaid savings reallocation to community programs prior to the reduction in resident census. Given the marginal staffing patterns at these facilities, staff reductions that would eventually provide Medicaid funds for community program costs, cannot be realized until community resources are in place and institutionalized residents are placed from the facilities.

VIII. Conclusion

1. Case management standing alone as a waivered service is not financially feasible and cost effective to the Commonwealth. The effectiveness of a case manager is dependent on the availability of community-based care service to which clients can be referred.

2. State/local funds potentially available by federal participation in a case management waiver are inadequate to finance the array of community-based services required to support a mentally retarded person in the community, even excluding the room and board costs which are not recoverable under Medicaid.

IX. Recommendations

Due to the limited cost effectiveness of case management, standing alone as the only waivered service, it is recommended:

1. A case management waiver not be requested at this time.

2. The Departments of Health and Mental Health and Mental Retardation expand their current efforts to develop a range of waivered services for the mentally retarded which would be cost effective to the Commonwealth and result in eligible clients being served in the community. Case Management will be one of those services. The target date for waiver submission will be July 1, 1984.

3. Earmark $2 Million projected 1984-86 Medicaid savings resulting from DMH/MR phase down of geriatric census to finance waiver implementation during 1984-86 biennium period.

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