REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

THE FEASIBILITY OF EXTENDING MEDICAID COVERAGE TO PERSONS WITH DEVELOPMENTAL DISABILITIES AND MENTAL ILLNESS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 19

COMMONWEALTH OF VIRGINIA
RICHMOND
1996

COMMONWEALTH of VIRGINIA

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December 22, 1995

TO: The Honorable George Allen

and

The General Assembly of Virginia

This report contained herein is pursuant to House Joint Resolution 632, agreed to by the 1995 General Assembly.

This report constitutes the response of the Department of Medical Assistance Services to this resolution and recommends the appropriate actions related to the feasibility and advisability of seeking a waiver that would extend Medicaid coverage to persons with developmental disabilities and mental illness.

Respectfully Submitted,

Robert C. Metcalf
Director, Department of Medical Assistance Services

Legislative Study Report on HJR 632

A Study of the Feasibility of Seeking a Waiver to Extend Medicaid Coverage to Certain Persons with Developmental Disabilities and Mental Illness

A study to determine the feasibility of seeking a waiver to extend Medicaid coverage to persons with developmental disabilities and mental illness who are no longer eligible for public programs due to their age, but who still require assistance, guidance, or supervision.

Prepared by:

Department of Medical Assistance Services
Division of Policy Development
October, 1995

Preface

House Joint Resolution No. 632 requested the Department of Medical Assistance Services (DMAS) to study the possibility of seeking a waiver to extend Medicaid coverage to persons with developmental disabilities and mental illness who are no longer eligible for public programs due to their age, but who still require assistance, guidance, or supervision. This resolution was a result of the work of the Joint Subcommittee Studying the Continuation of Services to Young Adults Exiting Publicly Funded Programs, established during the 1994 General Assembly through House Joint Resolution No. 103. Because of concerns about the ability of these young adults to lead independent lives, the Joint Subcommittee studied the continuation of services for young adults exiting publicly funded programs.

The possibility of covering the services needed by these young adults through Medicaid was one of the areas addressed by the Subcommittee. During the Joint Subcommittee's deliberations, DMAS was called upon to present the possibilities of covering this population under Medicaid. After careful analysis, five options for making Medicaid services available to the developmentally disabled and mentally ill population were offered by DMAS.

The feasibility and practicality of each option including the costs and benefits of the services are addressed in this document. Careful analysis revealed that significant programmatic and financial implications are associated with each option. Because of the uncertainty of the impending block grant approach to Medicaid and the implications of each option, it is recommended that no action be taken at this time to expand these services.

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Executive Summary

House Joint Resolution No. 632 requested the Department of Medical Assistance Services to study the possibility of seeking a waiver to extend Medicaid coverage to persons with developmental disabilities and mental illness who are no longer eligible for public programs due to their age, but who still require assistance, guidance, or supervision. This resolution originated from the work of the Joint Subcommittee Studying the Continuation of Services to Young Adults Exiting Publicly Funded Programs, established during the 1994 General Assembly through House Joint Resolution No. 103. Because of concerns about the ability of these young adults to lead independent lives, the Joint Subcommittee studied the continuation of services for young adults exiting publicly funded programs.

The possibility of covering the services needed by these young adults through Medicaid was one of the areas addressed by the Subcommittee. During the Joint Subcommittee's deliberations, DMAS was called upon to present the possibilities of covering this population under Medicaid. After careful analysis, the following options that could be used to make Medicaid services available for a population that is developmentally disabled and mentally ill were offered by DMAS:

1. Expand the Mental Retardation Waiver;
2. Expand the Elderly and Disabled Waiver;
3. Utilize the Assisted Living Waiver;
4. Submit a request for a waiver for persons with mental illness; and,
5. Expand the services available through the State Plan to provide additional community support services for persons with developmental disabilities.

This study examined the feasibility and practicality of each option including the costs and benefits of the services. The analysis revealed that each option had significant programmatic and financial implications. It is recommended that no action be taken at this time to expand these services, chiefly because of the uncertainty of the impending block grant approach to Medicaid.

Individuals must meet the financial eligibility criteria as Categorically Needy to participate in this waiver (i.e., person is disabled and eligible for Supplemental Security Income, person is eligible for Aid to Dependent Children, etc.) and there are nine services available to persons who meet the criteria for this waiver. The state is approved to offer these services as an alternative to institutionalization in an Intermediate Care Facility for Mentally Retarded (ICF/MR) as long as the services, in the aggregate, are no more costly than Medicaid expenditures for services in an ICF/MR.

Elderly and Disabled Waiver

This waiver is targeted to persons who would otherwise require care in a nursing facility. There are young adults in the community with developmental disabilities who utilize services through this waiver program. The number of persons that can effectively be served is limited by the fact that the person must meet criteria that are nearly identical as persons who are authorized to enter a nursing facility and by the limited range of services provided in the waiver. In FY 1993, approximately 870 of the 8,729 persons who received Elderly and Disabled Waiver services were in the age cohort of 21 to 44 years.

Individuals must meet the financial eligibility criteria as either Categorically Needy or Medically Needy (i.e., person must meet same categories as for Categorically Needy population, but income and resources may exceed the Categorically Needy limit) to participate in this waiver. Three services are provided in this waiver: Personal Care, Respite Care and Adult Day Health Care. The state is approved to offer these services as an alternative to institutionalization in a nursing facility as long as the services, in the aggregate, are no more costly than Medicaid expenditures for services in a nursing facility.

Technology Assisted Waiver

This waiver is targeted to persons under the age of 21 who are dependent on medical technology (i.e., ventilator dependent) to sustain life and require continuous and ongoing nursing care and would otherwise require Medicaid reimbursed hospital care. If an individual enters this waiver before age 21, the individual may continue to be served in the waiver, but someone 21 years of age or older cannot enter the waiver for the first time.

Individuals must meet the financial eligibility criteria as Categorically Needy or Medically Needy to participate in this waiver. Private Duty Nursing and Respite Care are provided in the waiver and DMAS provides case management services administratively. This waiver has served only three individuals who are more than 21 years old. The state is approved to offer these services as an alternative to ongoing hospital care (since there is no limit on the number of days of hospital care that Medicaid may pay for persons under the age of 21) as long as the services, in the aggregate, are no more costly than Medicaid expenditures for services to these types of children in a hospital.

AIDS/HIV Waiver

This waiver is targeted to persons with AIDS/HIV who have reached a level of dependency and require the services under the waiver to prevent more costly hospital care.

Individuals must meet the financial eligibility criteria as Categorically Needy or Medically Needy to participate in this waiver. Four services are provided in this waiver: Personal Care, Respite Care, Private Duty Nursing and Case Management. The state is approved to offer these services as an alternative to the more costly acute care and related expenditures that Medicaid-eligible individuals with AIDS/HIV experience. This waiver is not typically utilized by young adults with developmental disabilities.

Analysis

DMAS has identified five options that could be used to extend services to this population. Cost estimates of covering the services and preparing a waiver, if necessary, have been prepared for each of these options as well as an analysis of the likelihood that the option would be approved. In addition, a timeline has been established as to when the option could be implemented.

Options & Considerations: Medicaid Covered Services To Young Adults

1. Expand the MR Waiver

The current MR waiver target population could be expanded to serve persons with developmental disabilities. Most states' waivers are written to serve persons with mental retardation and persons with developmental disabilities since the services needed by both groups are usually similar. The current range of services is appropriate to meet most of the needs of persons with developmental disabilities who require community support. At the time the current MR waiver was developed, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) decided to include only persons with mental retardation perhaps because of its legal mandate and that of the Community Services Boards (CSBs) to serve persons with mental retardation.

Although the Code of Virginia does not specifically prohibit them from serving persons with developmental disabilities when there is no diagnosis of mental illness or mental retardation, it also does not authorize them, or allocate funds to serve, this broader population. There is no Medicaid requirement that limits services in an ICF/MR only to persons with mental retardation (ICF/MR criteria only requires a determination of dependency in categories of functional ability), so the waiver could legitimately be expanded to serve this population. HCFA regional office staff has recommended this expansion.

Considerations

- The number of young adults with a developmental disability who would meet the functional dependency level of care contained in the ICF/MR criteria is unknown. DMHMRSAS has begun to collect data on the number of persons on waiting lists for services through the MR waiver, but it is doubtful that individuals with developmental disabilities are included in the data since these persons would currently not be eligible for services through this waiver. The number of individuals currently served by Comprehensive Services Act (CSA) teams could significantly underreport the number of young adults who could utilize MR/DD waiver services since the CSA is only mandated to serve youth in special education and foster care. On the other hand, the number of persons served by CSAs is not necessarily indicative of the number of persons who would meet the ICF/MR criteria and receive waiver services.

- The average annual per capita expenditure for MR waiver services is $21,803. Considering the number of persons with developmental disability who would meet the ICF/MR criteria, expansion of the waiver to serve this additional population could adversely affect the Medicaid budget. Effective July 1, 1995, state general funds which were previously appropriated to DMHMRSAS' budget and then allocated to each of the CSBs for funding of community mental health/mental retardation services, will be appropriated to DMAS. This general fund money includes expected utilization increases based on historical trends since 1991. This state match will not be sufficient to fund services for an additional population of developmentally disabled persons. There is no requirement that there be any local match contributed in order to access federal matching funds (federal financial participation is 50 percent).

- Individuals with developmental disabilities are not viewed as part of the target population by DMHMRSAS and CSBs. The Virginia Association of CSBs has formally declined to expand the population they serve. Any addition to this waiver to address the developmentally disabled population will either require a change to the Code of Virginia to enable DMHMRSAS and CSBs to expand the population served or will require the development of a new, and in many ways, duplicative service administration system.

- Young adults who require services as a result of mental illness could not be incorporated into the definition of developmental disability recognized by HCFA in its waiver programs. Thus the population in need of services due to mental illness would not be served via this expansion. However, those persons who met pre-nursing facility criteria could be served in the Elderly and Disabled waiver and receive mental health services through the available State Plan service options.

2. Expand the Elderly and Disabled Waiver

This waiver already includes any young adult who has a developmental disability and meets pre-nursing facility criteria. For some young adults, the combination of the Personal Care

or Adult Day Health Care services with available State Plan services would be sufficient to maintain them in the community. Some persons receive Personal Care services in conjunction with habilitation services through DRS as well. In some instances, the young adult may not have a caregiver in the community who can provide the residence in which Personal Care could be provided. Furthermore, the individual may require more support than is available through an Assisted Living residence. The Elderly and Disabled waiver could be expanded to include small group home residential support or Adult Foster Care. This service, in conjunction with the available State Plan option and DRS services, should enable more individuals to remain in the community.

Consideration

The average annual per capita expenditures for all Medicaid services for the person with developmental disability would have to be less than the average annual per capita expenditures for all Medicaid services for a nursing facility resident; in FY 93 this was $14,676. For comparison, MR services must not exceed the average annual per capita expenditures of $53,566 for persons in ICF/MR. There would be a limited number of persons who would need to utilize the more costly group home supported living model (currently included in the MR waiver) without jeopardizing the Elderly and Disabled waiver's aggregate cost-effectiveness.

3. Utilize the Assisted Living Waiver

DMAS has been directed to request a waiver to reimburse for Intensive Assisted Living to persons who would otherwise require nursing facility level of care. Some young adults may be able to utilize this setting for residential living and receive additional support through State Plan community mental health and mental retardation services. Some Adult Care Residences have specialized in providing care to persons with mental retardation and mental illness. Efforts could be made to expand the available source of providers who could meet the needs of the wider range of the developmentally disabled.

4. Submit a Request for a Waiver for Persons with Mental Illness

Although DMAS already offers a variety of services for persons with mental illness through the State Plan, the service that is not necessarily available is residential support.

Consideration

There is one very significant barrier to this option: Virginia's Medicaid program does not reimburse for inpatient psychiatric services for persons with mental illness, except for children under the age of 21. Therefore, this option does not appear feasible for the population of young adults. A waiver could be developed based on a comparison with the cost for inpatient psychiatric care for persons under age 21, but the number of persons for whom this service is being reimbursed by Medicaid and the overall expenditures are so low that the state would be very hard pressed to demonstrate aggregate cost-effectiveness for community-based services offered to adults as well as children.

cognitive rehabilitation may be added to the waiver. Existing personal care requirements should be changed to permit personal care in a congregate setting.

- Use of new services by individuals currently in the waiver program can drive costs too high for cost effectiveness vis a vis nursing facility costs. Definition for new services could be written to restrict usage to physically disabled individuals.

- The current average annual expenditure per MR individual is $21,803.

- Because the range of services is more restrictive than available under the MR waiver, the average cost of service is expected to be 25 percent less than costs under the MR waiver, or $16,352.

- The same number of individuals in the community with developmental disabilities is assumed to be eligible as in Option 1. It is further assumed that one percent of the population currently in the elderly and disabled waiver will request more costly service. It is assumed that additional diversion at pre-admission screening from population entering nursing facilities would be one percent.

Applying the aforementioned assumptions results in the data depicted in Table 3.

Table 3. Option 2 Eligibles and Costs

No. Persons Expected to be Eligible	661
No. Persons Expected to be Eligible in First Year	165
Annual Cost Per Person	$16,352
First Year Cost	$2,702,168
Fourth Year Cost (1995 dollars)	$10,808,762

Option 3: Expand Assisted Living Waiver

The following considerations and assumptions were made under this option:

- The average length of stay in personal care is 230 days.

- 8,434 individuals were served in 1994 at an average expenditure of $6,188.

Applying the aforementioned assumptions results in the data depicted in Table 4.

Table 4. Option 3 Eligibles and Costs

No. Persons Expected to be Eligible	484
No. Persons Expected to be Eligible in First Year	121
Annual Cost Per Person	$6,188
First Year Cost	$748,748

Fourth Year Cost (1995 dollars)	$2,994,992

Option 4: Request a New Waiver

Assumptions applied to this option include the following:

- The types of services and providers in a waiver developed specifically for this population would likely be a blend of services provided in Options I and II.
- An individual can receive any combination of life skills coach, day support, supported employment, personal/respite care, assistive technology, case management, and cognitive rehabilitation.
- The waiver would have to be written as an alternative to ICF/MR for it to be cost effective.
- An individual with traumatic brain injury (TBI) has to meet ICF/MR criteria and have inadequate support to remain in the community.
- Assume a long term care program for TBI will be similar in annual costs to MR waiver.
- The current average annual expenditure per MR individual is $21,803.
- Assume 10 percent of the current number of Medicaid eligibles with TBI require long term care services.

Applying the aforementioned assumptions results in the data depicted in Table 5.

Table 5. Option 4 Eligibles and Costs

No. Persons Expected to be Eligible	50
No. Persons Expected to be Eligible in First Year	25
Annual Cost Per Person	$21,803
First Year Cost	$545,075
Fourth Year Cost (1995 dollars)	$2,180,300

Option 5: Expand State Plan Services

Assumptions made in this option include the following:

- Currently, no service program exists for persons in the community who require comprehensive rehabilitation but not nursing and physician services. Individual therapies are available through DMAS outpatient rehabilitation, however these services are not sufficiently comprehensive enough to permit community living.
- Long term care maintenance is available through existing waivers.

- The State Plan would be amended to offer under the rehabilitation option, cognitive rehabilitation in either a residential, day treatment, or home environment. Service would be for the individual who does not meet certified outpatient rehabilitation facility criteria but requires rehabilitation and community support. The same services would also be funded via Title I through the Department of Rehabilitative Services (DRS).

- Additional supportive services could be assisted living through the Department of Social Services; community alternatives to MH facilities through DMHMRSAS; long term care maintenance through waivers, etc. DMAS would also add targeted case management.

- Federal match is available for cognitive rehabilitation through DRS (Title I) and DMAS (Title XIX). Title I federal financial participation is 80 percent and Title XIX match is 50 percent. Criteria for service must be the same whether cognitive rehabilitation is reimbursed via Title I or Title XIX.

- Service providers have to meet established staffing criteria but do not have to be licensed as certified outpatient rehabilitation facilities or hospitals. DRS would be the authorizing agent.

- The cognitive rehabilitation pilot program offers residential and day treatment. Service utilization from this pilot is used to estimate costs. DMAS estimates from HJR 573 are used for estimating in-home service.

- Residential average length of stay is 4.5 months at $35,990 per individual.

- Day treatment average length of stay is 4.5 months at $10,501 per individual.

- In home average length of stay is six months at $17,160 per individual.

- Targeted case management (only for coordination of in-home services) average length of stay is six months at $1,200 per individual.

Applying the aforementioned assumptions results in the data depicted in Table 6.

Table 6. Option 5 Eligibles and Costs

No. Persons Expected to be Eligible	260
No. Persons Expected to be Eligible in First Year	65
Annual Cost Per Person	$6,188
First Year Cost	$1,282,256
Fourth Year Cost (1995 dollars)	$4,873,024

Conclusions and Recommendations

At this time, DMAS recommends that no action be taken with respect to seeking a waiver to extend Medicaid coverage to persons with developmental disabilities and mental illness who are no longer eligible for public programs because of their age, but who still require assistance, guidance, or supervision. Virginia Medicaid covers community and institutional based mental health services for children. Once the child reaches adulthood, psychiatric hospital care is no longer covered-the federal Medicaid law does not allow this service for persons age 21 and older. If a federal block grant becomes available to the states for services to the mentally ill, the coverage of psychiatric hospital care could be developed for adults.

APPENDIX A

House Joint Resolution No. 632

LD4397476

HOUSE JOINT RESOLUTION NO. 632

Offered January 23, 1995

Requesting the Department of Medical Assistance Services to seek a waiver extending Medicaid coverage to persons with developmental disabilities and mental illness.

Patrons—Van Landingham, Christian, Cooper, Darner and Van Yahres; Senators: Barry, Miller, Y.B. and Potts

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Referred to Committee on Rules

WHEREAS, states are required to comply with federal laws that protect the rights and interests of individuals with disabilities and require early identification of such persons, and to provide for the delivery of individualized and specialized education and training and related support services; and

WHEREAS, the Joint Subcommittee Studying the Continuation of Services to Young Adults Exiting Publicly Funded Programs, pursuant to HJR 103 (1994), has determined that many persons with developmental disabilities and mental illness require specialized services long after they have become ineligible for services; and

WHEREAS, the Department has successfully requested waivers to extend Medicaid services to other medically needy persons; and

WHEREAS, under current Medicaid regulations, persons with developmental disabilities and mental illness may not be eligible for Medicaid benefits and services; and

WHEREAS, if such persons were eligible for Medicaid services, their immediate and long-term needs could be met; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services is requested to seek a waiver to extend Medicaid coverage to persons with developmental disabilities and mental illness.

All agencies of the Commonwealth are requested to provide assistance to the Department, upon request.

The Department is requested to complete its work in time to submit its findings and recommendations to the Governor and the 1996 General Assembly as provided in the procedures of the Division of Legislative Automated Services for the processing of legislative documents.

Official Use By Clerks

Passed By The House of Delegates		Passed By The Senate	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Clerk of the House of Delegates | Clerk of the Senate