REPORT OF THE
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

Assessment of Reimbursement Rates for Medicaid Home and Community-Based Services

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

The 2005 Appropriation Act directed JLARC to report on the adequacy of Medicaid reimbursement rates for home and community-based care services and the impact of reimbursement levels on access to care for the Medicaid recipient population. This study was based on concerns among providers and recipients of home and community-based services that Medicaid reimbursement rates for these services are too low and may result in inadequate access to care for eligible recipients.

It appears that concerns about the negative effects of reimbursement rates on access in certain regions of the State are not warranted. Data do not support concerns over reduced access to services in rural localities or in the Southwestern and Southside regions of the State. Further, in recent years more providers have entered the market than have left it.

However, there is evidence to support providers' concerns that rates are low. Rates are not routinely adjusted for inflation, Virginia's rates are lower than in other states, and current rates do not appear to enable providers of some services to pay direct care staff either a competitive or living wage. Based on this evidence, options are included in this report for how rates could be adjusted.

A number of issues regarding the rate structure for services provided to individuals with mental retardation and developmental disabilities also warrant additional review. First, it appears appropriate to provide a Northern Virginia rate adjustment for services provided to people with mental retardation and developmental disabilities, which would be consistent with how most other home and community-based services are reimbursed. Also, there is a need to review the rate structure for services provided for these individuals in a group setting.

One behalf of the JLARC staff, I wish to express our appreciation for the assistance and cooperation provided during the course of this study by the Department of Medical Assistance Services, provider and recipient associations, and home and community-based service providers and recipients.

Philip A. Leone
Director

JLARC Report Summary

In recent decades, there has been increased recognition of many individuals' desire to live in their homes and communities, regardless of their age and health condition, and the nationwide trend has been to transition elderly people and those with disabilities from institutions to home and community-based settings. Many of the services required to sustain persons in community-based settings are funded through waivers to the Medicaid program. However, many home and community-based (HCB) services have received only minor adjustments to their Medicaid rates over the past decade, and some services have not received any rate adjustments over this period. This has resulted in concerns among both providers of waiver services and recipients that State Medicaid rates are too low and may translate into inadequate access to care for Medicaid-eligible recipients. These concerns led to language in the 2005 Appropriation Act directing JLARC to report on the adequacy of Medicaid reimbursement rates for HCB services and to examine the impact of those rates on access to care for the Medicaid recipient population.

This study found that there are conflicting indicators regarding the adequacy of current Medicaid reimbursement rates for HCB services. The apparent availability of services throughout the State and the increase in the number of providers entering the market suggest that concerns about the negative effects of reimbursement rates on access in certain regions of the State are not warranted. However, HCB service providers indicate that rates are too low, and there is evidence to support their position. The rates have not been routinely adjusted for inflation over the last ten years, and some rates are lower than in other states. In addition, the current rates do not appear to enable some providers to pay direct care staff a competitive or living wage. There are also several other issues regarding rates that warrant additional review.

Concerns Over Reduced Access to Home and Community-Based Services in Certain Regions Do Not Appear Warranted

Providers have frequently said that the Medicaid reimbursement rates could result in increased problems of access in certain regions of the State. Therefore, JLARC staff examined two frequently voiced concerns in particular:

- Do the Southwestern and Southside regions of the State tend to have relatively lower proportions of their populations receiving Medicaid home and community-based services? Therefore, is there less access to these services in these regions?

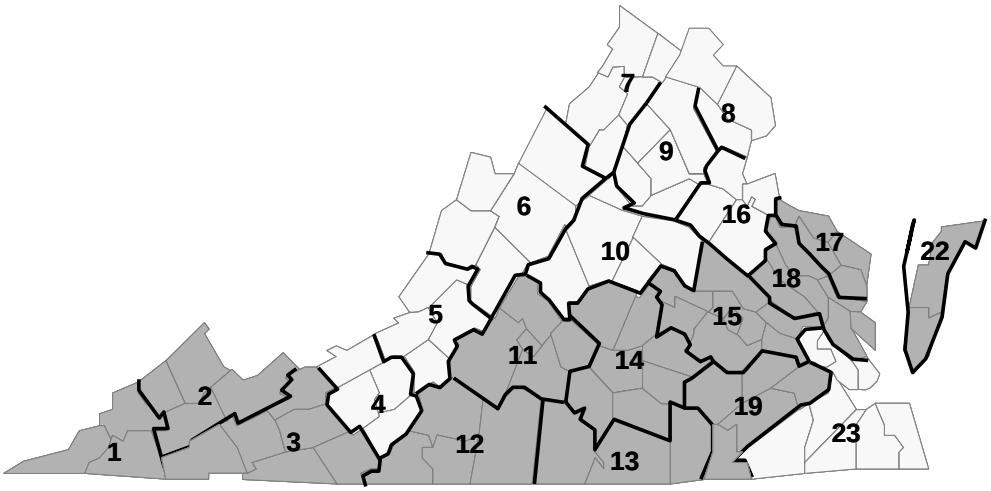
- Do rural localities (localities with lower population density) tend to have relatively lower proportions of Medicaid recipients receiving home and community-based services compared to urban localities? Therefore, do Medicaid recipients in rural localities appear to have less access to these services?

An analysis of the location of Medicaid recipients of HCB services and of trends among providers indicates that these concerns are not warranted. JLARC staff examined the geographic distribution of Medicaid waiver recipients for each of the six largest service categories (personal care, respite care, congregate residential services, in-home residential services, day support, and private duty and skilled nursing). For each category of service, the recipient data did not indicate that Southwestern or Southside regions of the state were proportionally underserved compared to the rest of the State. JLARC staff also examined access to services based on population density. Again, despite the concerns that rural localities ma be underserved, the data did not show that there is less utilization of services in rural localities than in urban localities.

Personal care, which is the most frequently used Medicaid waiver service, illustrates how the data do not support these concerns. The map below shows that, when controlling for poverty population and summarizing the data at the plannin district commission (PDC) level, Medicaid waiver recipients in the Southwestern and Southside regions do not appear to have substantially less access to personal care. In contrast, the map shows that in many Southwestern and Southside PDCs, the proportions of the local poverty populations receiving these services tend to be higher than the statewide average.

Geographic Distribution of Personal Care Services

Proportions of local poverty population that are Medicaid recipients receiving services



Key to Planning Districts

1. LENOWISCO
2. Cumberland Plateau
3. Mount Rogers
4. New River Valley
5. Fifth
6. Central Shenandoah
7. Lord Fairfax
8. Northern Virginia
9. Rappahannock-Rapidan
10. Thomas Jefferson
11. Central Virginia
12. West Piedmont
13. Southside
14. Piedmont
15. Richmond Regional
16. RADCO
17. Northern Neck
18. Middle Peninsula
19. Crater
22. Accomack-Northampton
23. Hampton Roads

Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

Similarly, data on the location of Medicaid waiver recipients do not support the concern that individuals in rural areas have less access to personal care than recipients in urban areas. Localities with lower population densities did not consistently have lower proportions of their poverty populations receiving Medicaid personal care services and, therefore, do not appear to have less access to services. Findings for other services were similar to those for personal care.

One region that did tend to have consistently lower proportions of its population receiving Medicaid waiver services is Northern Virginia. However, this may be partially explained by the region's lower proportion of persons eligible for Medicaid and the availability of alternative programs that may meet the needs of those seeking community-based services.

Three factors may help explain why the expected relationships between relative access to services and geographic location are not supported by the data. First, some providers can service broad geographic areas. Also, over the past four years more providers have entered the market than have left it. Further, some providers are more mission-driven than profit-driven and serve clients because they see a need, even in areas of the State where it may not be profitable to provide services.

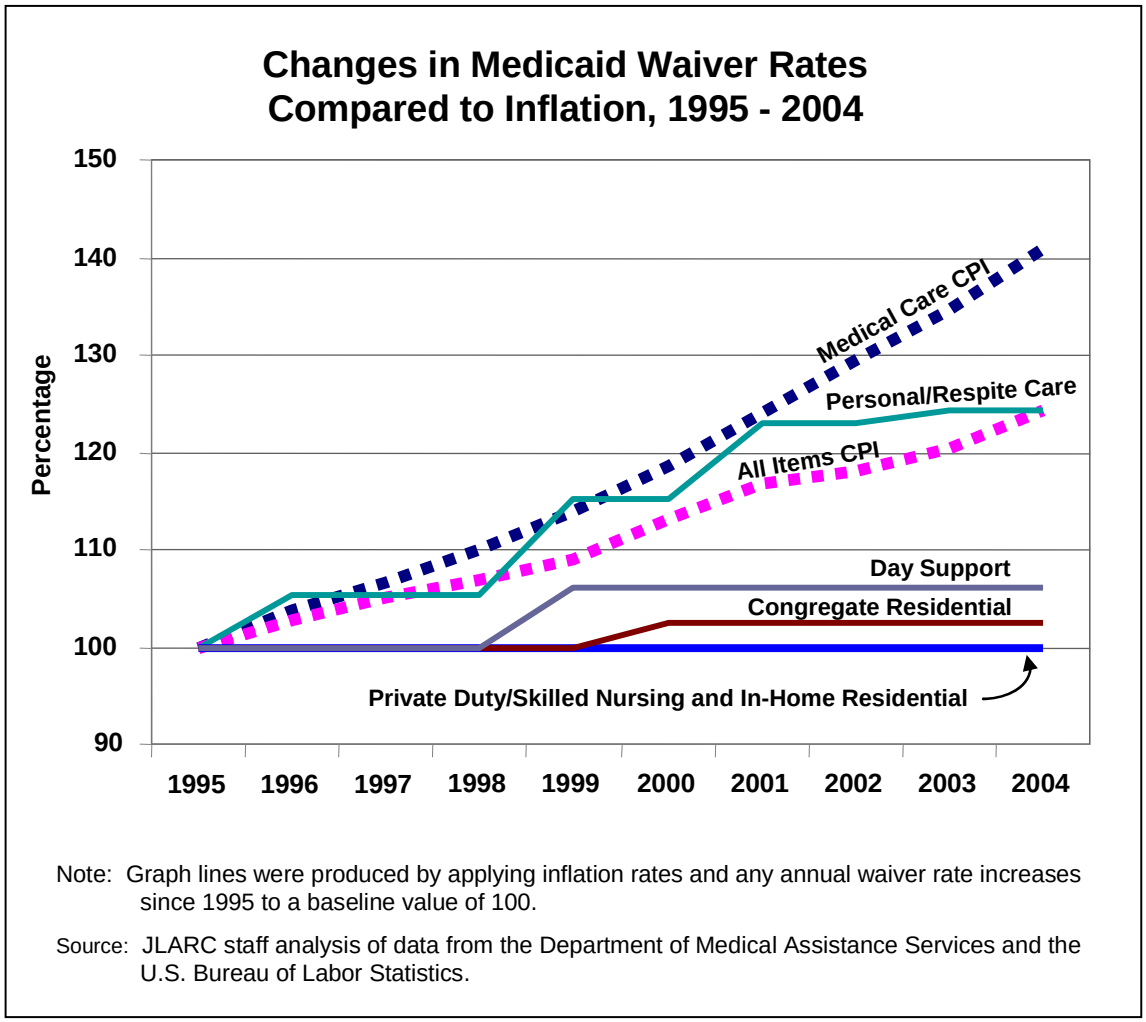
However, the findings on regional access require two caveats. First, the geographic distribution of some Medicaid waiver recipients may reflect other factors, such as the allocation of waiver slots, which are not related to Medicaid reimbursement rates. Also, there are some reported cases of individuals who are unable to find services or who have more difficulty finding services in certain areas.

Virginia's Patient Pay Prevents Some Individuals from Accessing Waiver Services

Although concerns over expected regional gaps in access to Medicaid home and community-based services do not appear warranted, Virginia providers indicated that the required co-payment (called the "patient pay") required of some individuals can be a major barrier to their ability to receive waiver services. In Virginia, individuals with a patient pay generally are only allowed to keep a personal maintenance allowance of 100 percent of federal Supplemental Security Income (SSI) for all of their personal expenses, including rent, food, utilities, and other incidentals. Based on Virginia's relatively low personal maintenance allowance (Virginia ranks in the bottom ten states in this allowance), it appears that some individuals have decided that they cannot afford to receive HCB services through a Medicaid waiver. In recognition of the barriers that the patient pay can present, there have been recent attempts to increase the personal maintenance allowance for individuals receiving Medicaid waivers. However, these efforts have not been adopted by the General Assembly.

Evidence Supports Providers' Concerns that Rates Are Too Low

Many providers have indicated that current rates for HCB services are too low, and there is some evidence to support these claims. One factor supporting the providers' position is that Medicaid rates generally have not risen with inflation. As shown in the figure below, only the rate increases for personal care and respite services approximated the overall increase in the Consumer Price Index (CPI) over the past ten years. The disparity between inflation growth and the rates is even greater when using the Medical Care CPI, which captures inflation for the medical industry and may be a more reliable indicator of the increased costs for some HCB providers, such as personal care and private duty and skilled nursing providers.



Note: Graph lines were produced by applying inflation rates and any annual waiver rate increases since 1995 to a baseline value of 100.

Source: JLARC staff analysis of data from the Department of Medical Assistance Services and the U.S. Bureau of Labor Statistics.

A comparison of Virginia's rates for selected services with rates in other states also appears to support the providers' assertion. Among selected states in the Southeast and mid-Atlantic regions in which rates are comparable, Virginia ranks towards the bottom in terms of the reimbursement rates it pays for personal care, private duty and skilled registered nurse (RN) services, and private duty and skilled licensed practical nurse (LPN) services.

Further evidence supporting providers' concerns is that current reimbursement rates do not allow providers to pay a competitive wage or a living wage to direct care staff for services provided on an individual basis. The most significant factor affecting provider costs is the wage providers pay to direct care staff. Therefore, JLARC staff used two approaches to examine whether current reimbursement rates cover potential provider costs – the comparable position approach and the living wage approach. The comparable position approach bases wages on what the State or nursing homes pay staff in comparable positions. The living wage approach assumes that providers will pay direct care staff at least enough that they will not qualify for government assistance. The current Medicaid rates do not appear to allow most providers to pay either a competitive wage or a living wage for direct care staff and still pay overhead costs for one-on-one services, such as personal care, respite care, and in-home residential support.

Options for Adjusting Medicaid Rates for Inflation and Rebasing Rates for Some Services

The claims by providers that Medicaid rates are too low and the evidence supporting these claims may warrant further consideration of whether rates for some HCB services should be increased. One way to adjust rates for these services is to provide for annual adjustments using the Consumer Price Index (CPI). If FY 2004 rates for the six largest services were increased annually by the CPI, they would be 5.1 percent higher in FY 2006 and would cost the State an additional $10.2 million annually. An alternative would be to adjust rates for services that compete for staff with the medical community, namely private duty and skilled nursing, personal care, and respite care providers, using the Medical Care CPI. If FY 2004 rates for these services were increased by the Medical Care CPI annually, they would be 8.6 percent higher in FY 2006 and would cost the State $2.9 million more than using the CPI for all goods and services.

Another option is to rebase rates for services provided in an individual setting using cost estimates based on either the living wage approach or the comparable position approach. It is estimated that rebasing rates for personal care, respite care, private duty and skilled nursing, and in-home residential support using the comparable position approach would cost the State an additional $62.8 million to $65.9 million annually. Rebasing rates for personal care, respite care and in-home residential support using the living wage approach would cost the State an additional $23.3 million to $24.1 million annually. (Current rates for private duty and skilled nursing services are above costs estimated using the living wage approach.) The State cost for any increase in rates through either an inflation adjustment or by rebasing them would be matched by federal Medicaid funds.

Northern Virginia Rate Adjustment Is Appropriate for Mental Retardation and Developmentally Disabled Services

Most HCB services receive a rate differential for Northern Virginia reflecting the higher cost of living in this region of the State. However, several services provided exclusively through the Mental Retardation (MR) and Individual and Fam-

ily Developmental Disabilities Support (DD) waivers do not receive this regional differential. There is adequate evidence supporting the notion that provider costs, particularly wage costs, are higher in Northern Virginia, and these higher wages would affect all HCB services that make use of direct care staff. Therefore, it would be appropriate to provide a Northern Virginia differential for services under the MR and DD waivers that are not currently receiving this regional adjustment. The cost to the State of providing a 17.5-percent rate differential for congregate residential, in-home residential, and day support reimbursement rates is estimated to be approximately $4.6 million in general funds annually. These costs would be matched by federal Medicaid funds.

Other Issues with the Rate Structure for MR and DD Waiver Services

Two issues related to services provided under the MR Waiver and the DD Waiver were identified during this study and warrant additional review:

(1) Current Medicaid HCB services provided in a group setting, such as congregate residential support, are largely reimbursed on a constant per-recipient basis that does not take into account variation in factors such as the health condition of the recipient, the needs of the recipient, or the staff-to-client ratios utilized by the provider. Therefore, rates may be too low in some situations, adequate in others, and too high in still other situations. Virginia is one of the few states that does not adjust rates for group MR and DD waiver services based on these types of factors. Therefore, it may be appropriate to review alternative rate structures for services provided in group settings to determine whether Virginia should revise the rate structure to more closely align reimbursement rates with the level of service provided.

(2) Virginia currently does not reimburse congregate residential support providers for general supervision costs. General supervision most frequently consists of overnight supervision of group home residents. According to Department of Medical Assistance Services staff, providers are prohibited from billing Medicaid for general supervision costs due to federal guidelines. However, possible changes to these guidelines may allow the State to begin reimbursing providers for these costs.

It may be most appropriate for a working group to address these two issues further. This working group could include relevant State agencies, HCB services providers, recipients of Medicaid waiver services, and relevant provider and recipient associations.

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I. Introduction

Regardless of their age or condition, most persons who are elderly or disabled share common goals: to have control over their lives and to be integrated with the rest of society. In recent decades, the desire of these individuals to live in their homes and communities has been increasingly recognized, and the national trend has been to transition people who are elderly and disabled from institutions to home and community settings. Further, states have recognized that home and community-based (HCB) services not only provide a higher quality of life but also are more cost effective. Compared to the cost of institutional care, home and community-based care is about one-third to one-half the per capita cost.

The increased emphasis on home and community-based services can be observed in the expenditure trends for long-term care. Medicaid is the primary payer for long-term care services in the United States. As Medicaid long-term care expenditures have continued to increase, HCB services have made up an increasingly larger share of those expenditures. In Virginia, Medicaid expenditures for home and community-based care have increased from only seven percent of the total Medicaid long-term care budget in FY 1985 to 32 percent of those expenditures in FY 2004.

As states have worked to rebalance long term care services from institutional to community settings, reimbursement methodologies have not always followed. In Virginia, the long term care financing policies support institutionalization over community-based care. For example, nursing facilities' reimbursement rates are rebased on a regular basis and annual inflation is also provided. However, the rates for most HCB services have changed very little over the past decade. The increase in Medicaid expenditures for HCB services in Virginia has been driven largely by increased numbers of individuals using these services and not by increased Medicaid reimbursement rates. As a result, there has been increased concern over whether current rates are adequate and whether access to these services for eligible individuals is being affected accordingly. Consequently, JLARC was directed to report on the adequacy of HCB service rates and the impact of reimbursement levels on access to care for the Medicaid recipient population.

This study found that there are conflicting indicators regarding the adequacy of current Medicaid reimbursement rates for HCB services. The availability of services throughout the State and the increase in providers entering the market suggest that concerns about the negative effects of reimbursement rates on access in certain regions of the State are not warranted. However, HCB service providers assert that rates are too low, and there is evidence to support their concerns. Most rates have not been routinely adjusted for inflation over the last ten years, and rates in Virginia are lower than in other states. In addition, the current rates do not appear to enable some providers to pay direct care staff a competitive or living wage.

HOME AND COMMUNITY-BASED SERVICES IN VIRGINIA

Home and community-based services in Virginia are provided through both the Medicaid State plan and waivers to the State plan. The vast majority of HCB services are provided through the waivers. Home health, which is more frequently provided for post-recovery episodic care, is the only HCB service provided entirely through the State plan and makes up less than one percent of spending on home and community-based care in Virginia. Additionally, Medicaid home health rates are increased annually to account for inflation, and providers indicated that they are generally satisfied with the Medicaid home health rate. Therefore, the primary focus of this report is on the Medicaid HCB services that are provided through waivers to the State plan.

Virginia offers HCB services through six waivers to its Medicaid State plan. These services are referred to as waiver services because Section 1915(c) of the Social Security Act allows states to waive the Medicaid requirement of statewide coverage and to target specific populations for service, such as the elderly and disabled and persons with mental retardation or developmental disabilities. In FY 2004, Virginia served over 17,000 individuals through home and community-based waiver services. Waiver recipients are limited to individuals who are at risk of institutionalization, such as placement in a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF/MR).

Virginia first began offering HCB waivers in 1982 with the establishment of an Elderly and Disabled Waiver that was limited to personal care. In the past two decades, Virginia's various waiver programs have evolved into the six HCB waivers currently offered in 2005, which are set forth in the *Virginia Administrative Code* (Title 12, Agency 30, Chapter 120):

- Elderly and Disabled with Consumer Direction (ED/CD) Waiver
- Mental Retardation (MR) Waiver
- Day Support Waiver
- Technology Assisted Waiver
- AIDS Waiver
- Individual and Family Developmental Disabilities Support (DD) Waiver

The most recent changes to Virginia's waiver programs occurred in 2005. The Day Support Waiver was newly established in 2005 with the intent to serve individuals on the waiting list for the MR Waiver. In addition, two formerly separate waivers, the Elderly and Disabled (E&D) Waiver and the Consumer-Directed Personal Attendant Services (CD-PAS) Waiver, were combined into the ED/CD Waiver.

Majority of Payments for Home and Community-Based Waiver Services Are Made Across Six Service Lines

Virginia's six HCB waivers cover a wide variety of services. However, the vast majority of waiver payments are made for a few services. The services which receive the greatest share of payments are congregate residential services, personal

care, day support, private duty and skilled nursing services, in-home residential services, and respite care.

Table 1 displays the full range of services that are offered across the various HCB waivers. The MR and DD waivers offer the largest array of services, while the newly established Day Support Waiver is confined to day support and prevocational services.

Table 1

Services Covered Under Virginia's Home and Community-Based Waivers

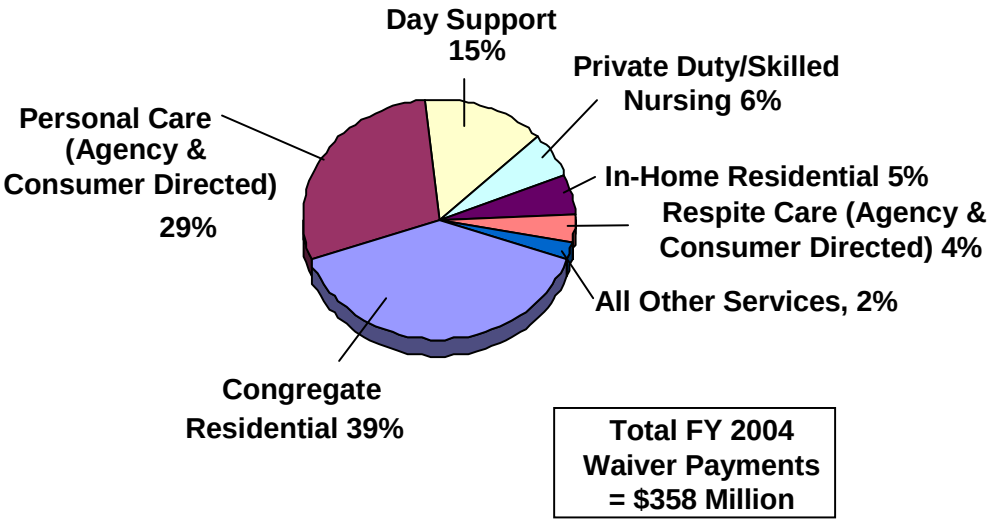
Waiver Services	ED/CD Waiver	MR Waiver	Day Support Waiver	Technology Assisted Waiver	AIDS Waiver	DD Waiver
Adult Companion Care						
Agency		X				X
Consumer Directed		X				
Adult Day Health Care	X					
Assistive Technology		X		X		X
Congregate Residential		X				
Environmental Modifications		X		X		X
Case Management					X	
Crisis Stabilization		X				X
Day Support/Prevocational Services						
Regular		X	X			X
High Intensity		X	X			X
Family/Caregiver Training						X
In-Home Residential		X				X
Nutritional Supplements					X	
Personal Care – Agency						
Agency	X	X		X	X	X
Consumer Directed	X	X				X
Personal Emergency Response System	X	X				X
Respite Care						
Agency	X	X		X	X	X
Consumer Directed	X	X				X
Skilled/Private Duty Nursing						
RN		X		X	X	X
LPN		X		X	X	X
Supported Employment-						
Individual		X				X
Enclave		X				X
Therapeutic Consultation		X				X

Source: Based on information provided by the Virginia Department of Medical Assistance Services.

Figure 1 indicates the percentages of payments made in FY 2004 for the different services offered through the waivers according to the *FY 2004 Statistical Record of the Virginia Medicaid Program*. As shown in Figure 1, just six services made up 98 percent of total waiver payments. Congregate residential services and personal care made up 68 percent of the payments, and day support (which includes prevocational services), private duty and skilled nursing services, in-home residential services, and respite care made up another 30 percent of waiver payments. The remaining two percent waiver payments were spread across the 13 remaining services listed in Table 1.

Figure 1

Percentage of Payments by Service Type, All HCB Waivers, FY 2004



Source: JLARC staff analysis of data in the *FY 2004 Statistical Record of the Virginia Medicaid Program*.

Because nearly all funding for waiver services is concentrated in six main services, the study focused on those services. A description of each of those services is included below. A description of all services listed in Table 1 is included in Appendix B.

- ***Congregate Residential Services*** – Provided under the MR Waiver. Includes training, assistance, or specialized supervision provided primarily in a licensed or approved residence to enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Enables individuals to maintain or improve their health, to develop skills in activities of daily living (ADLs), to adapt their behavior to community and

home-like environments, to develop relationships, and to participate as citizens in the community. To qualify for this service, the individual must demonstrate a need for continuous training, assistance, and supervision for up to 24 hours per day provided by a Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) licensed residential provider.

- ***Personal Care Services (Agency and Consumer Directed)*** – The most frequently accessed HCB service, and provided under all of the waivers except the Day Support Waiver. Includes long-term maintenance or support services necessary to enable the recipient to remain at or return home rather than enter a nursing care facility. Personal care aides assist with the recipient's ADLs, such as bathing, dressing, transferring between a bed and chair, and meal preparation. With agency personal care services, the recipient receives services from a Medicaid-registered personal care agency. With consumer-directed personal care services, recipients or their families are in charge of the hiring, training, supervision, and firing of the personal care aide. Consumer-directed personal care services are not available under the Technology Assisted Waiver.

- ***Day Support Services*** – Provided under the MR, DD, and Day Support Waivers. Includes training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. Typically takes place outside the home and focuses on enabling individuals to attain or maintain their maximum functional level.

- ***Private Duty and Skilled Nursing*** – Private duty nursing provided under the Technology Assisted Waiver and skilled nursing provided under the AIDS, DD, and MR waivers. Vast majority of nursing services (90 percent) provided through the Technology Assisted Waiver. Provided by a Registered Nurse or a Licensed Practical Nurse. These services are ordered by a physician and required to prevent institutionalization.

- ***In-Home Residential Services*** – Provided under the DD and MR Waivers. Provided in the individual's home by a DMHMRSAS-licensed residential provider or a Department of Social Services (DSS)-approved provider of adult foster care services. Includes training and assistance or specialized supervision that is provided to enable individuals to maintain or improve their health, develop skills in ADLs, adapt their behavior to community and home-like environments, develop relationships, and participate as citizens in the community.

- ***Respite Care (Agency and Consumer-Directed)*** – Provided under all of the waivers except the Day Support Waiver. Provides temporary, but periodic or routine, relief to the primary unpaid caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. Includes assistance with personal hygiene, nutritional support, nursing assistance, and environmental maintenance. Personal care services are

most often accessed through respite care. With agency respite care services, the recipient receives services from a Medicaid-registered respite care agency. With consumer-directed respite care services, recipients or their families are in charge of the hiring, training, supervision, and firing of the personal care aide. Consumer-directed respite care services are not available under the Technology Assisted Waiver.

Summary of Virginia's Home and Community-Based Waivers

Virginia provides home and community-based services through six different Medicaid HCB waivers. However, as noted previously, several changes have occurred to the waivers as recently as 2005. Because the most recent data available from the Department of Medical Assistance Services (DMAS) was for FY 2004 at the time analysis was done for this report, FY 2004 will constitute the base year for this report. Even though the waivers were configured slightly differently in FY 2004, all of the same services were provided in FY 2004 as are currently provided.

Table 2 includes the total number of recipients served by each of Virginia's waivers in FY 2004 and the total waiver costs. In FY 2004, 17,083 individuals received an HCB waiver in Virginia, with the largest number of individuals (10,161) receiving the E&D waiver. The next largest waiver, on a recipient basis, was the MR waiver, which was received by 5,622 individuals. The remaining waivers were substantially smaller, serving a total of 1,300 individuals across all four waivers.

Table 2 also includes the costs for each waiver and shows that waiver costs are not solely related to the number of recipients served. Approximately two-thirds of waiver recipients received the E&D waiver, but the MR waiver had more than twice the total waiver cost: $101.4 million for the E&D waiver compared to $227.2 million for the MR waiver. The differences in per-recipient waiver costs can be explained by the varying average cost per person across different waivers, which reflect differences in the intensity of services provided. For example, while an E&D waiver recipient may typically receive four to six hours of services per day, many individuals on the MR waiver receive up to 16 or more hours of services daily.

The U.S. Centers for Medicare and Medicaid Services (CMS) has several requirements regarding state waiver programs. First, all HCB waivers must be cost effective so that it costs no more on average to provide HCB services than to provide institutional care. In addition to the cost effectiveness requirement, CMS also requires that individuals receiving Medicaid HCB waivers meet the same eligibility criteria that are used for admission to an institution. (The waiver eligibility criteria are summarized in Exhibit 1.) This does not mean, however, that individuals must be placed in an institution if they are unable to or decide not to access waiver services.

Table 2

Home and Community-Based Waivers Covered by Medicaid in Virginia, FY 2004

Waiver	# of Recipients	Total Waiver Costs
Elderly and Disabled (E&D)	10,161	$101,354,887
Consumer-Directed Personal Attendant Services (CD-PAS)	417	4,403,107
Mental Retardation (MR)	5,622	227,229,982
Technology Assisted	339	19,648,061
AIDS	274	608,497
Individual and Family Developmental Disabilities Support (DD)	270	4,737,002

Source: Based on data in the *FY 2004 Statistical Record of the Virginia Medicaid Program.*

Exhibit 1

Summary of Eligibility Criteria for Medicaid Home and Community-Based Waivers

Financial Criteria

Individual's income can be no greater than 300 percent of federal Supplemental Security Income (SSI).

- When a person is institutionalized, or screened and approved for waiver services, only the individual's income and resources are counted in determining his eligibility.
- Individuals with higher income may achieve eligibility for the AIDS, ED/CD, and Technology Assisted waivers if they incur medical expenses that reduce their countable income.

Functional Criteria

Criteria are based on the functional criteria used for admission to an ICF/MR or a nursing facility, depending on the alternative institutional placement for the particular waiver.

- In addition to functional criteria, nursing facility criteria also require individuals to have medical and/or nursing needs.

Source: Information provided by the Department of Medical Assistance Services (DMAS) and *Home and Community-based Services for People with Disabilities Medicaid Waiver Services Guide*: Norfolk Endependence Center.

The alternative institutional placements for the Medicaid waiver programs varies depending on the waiver and includes nursing facilities, intermediate care facilities for the mentally retarded (ICF/MRs), and hospitals. A summary of each of the waivers follows.

Elderly and Disabled (E&D) and the Consumer-Directed Personal Attendant Services (CD-PAS) Waivers. The E&D Waiver is targeted to individuals who are 65 and older or disabled, meet the nursing facility level of care criteria, and are determined to be at risk of nursing facility placement. HCB services provided under this waiver are the critical services that enable the individual to remain at home rather than being placed in a nursing facility. In FY 2004, 10,161 individuals received services through the E&D Waiver. Case Example 1 profiles an individual who would be a good candidate to receive services through the E&D Waiver, which became the Elderly and Disabled with Consumer Direction (ED/CD) waiver in 2005 (as discussed below).

The CD-PAS waiver was an alternative to the E&D waiver. The CD-PAS waiver only covers personal care services, but it allows recipients to take charge of their own care, including the hiring, training, supervision, and firing of the personal attendant. In FY 2004, 417 people received services through the CD-PAS Waiver.

In February 2005, the E&D and CD-PAS waivers were combined into the Elderly and Disabled with Consumer Direction (ED/CD) Waiver. The cap for the combined waiver is 10,579 individuals receiving services at any given time, and has not been reached. Figure 2 shows the distribution of services provided under the

Case Example 1

Abby is an 86-year-old woman who has physical limitations due to debilitating arthritis. She also has type II diabetes. Abby is chair-bound, has developed a pressure ulcer, and is dependent on assistance for activities of daily living such as dressing, bathing, and walking. She is alert and oriented, but her prognosis is for little or no recovery, with decline in her current condition possible.

Abby's husband, who served as her primary caregiver, recently died. Abby has moved in with her 82-year-old sister who provides assistance with Abby's needs. However, her sister has limited strength and is unable to help with all of Abby's needs.

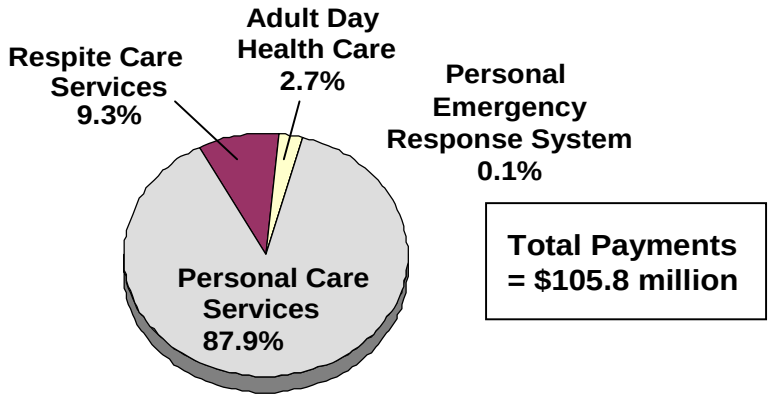
Abby's financial status qualifies her to receive Medicaid waiver services. Based on Abby's level of functioning, Abby would be a good candidate to receive personal care services in her home under the ED/CD waiver rather than going into an institution. Receiving services through the ED/CD waiver would allow her to continue living with her sister, as she prefers, and would be more cost effective.

Source: Based on case studies included in the U.S. General Accounting Office report, *Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably*, GAO-02-1121 (Washington, D.C.: September 26, 2002)

Figure 2

Elderly and Disabled Waiver and Consumer-Directed Personal Attendant Services Waiver, FY 2004

Percentage of Payments by Service Type



Source: *The FY 2004 Statistical Record of the Virginia Medicaid Program.*

E&D Waiver and the CD-PAS Waiver combined based on total payments for services in FY 2004. Most payments were for personal care services, which is not surprising given that all E&D Waiver recipients received personal care services, and personal care was the only service available under the CD-PAS Waiver. The next largest share of payments was made for respite care, which as mentioned previously, is often personal care services on a temporary basis provided to relieve the primary, unpaid caregiver.

Mental Retardation Waiver. The MR waiver is available for the provision of home and community-based care to eligible clients with mental retardation who would otherwise require placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). In FY 2004, 5,622 individuals received services through the MR Waiver. For FY 2005, the General Assembly increased the slots for this waiver to 6,571 individuals at any given time. As of June 2005, there were 2,832 individuals on the urgent and non-urgent waiting lists to receive the MR waiver, with 193 of those receiving services through the ED/CD Waiver (which is permitted under CMS regulations). An individual receiving the MR Waiver is profiled in Case Example 2.

Figure 3 shows the distribution of payments provided under the MR Waiver in FY 2004. The largest percentages of payments were made for congregate residential support and day support. Together, these two services made up 84 percent of MR Waiver payments. The remaining 16 percent of payments were split between in-home residential support services and all other MR waiver services, including personal care and supported employment.

Case Example 2

Matt is a 30-year-old individual with cerebral palsy and moderate mental retardation. Matt is medically fragile, having gone through surgeries, and requires a feeding tube. Matt lived at home with a mother who suffered from frequent mental health problems, often resulting in her being unable to care safely for her son. Matt was very isolated at home and had very limited resources for his care and daily living needs. When Matt began receiving the MR Waiver and came to the day support program, he was very quiet and frustrated by his inability to communicate, being able only to gesture yes and no responses.

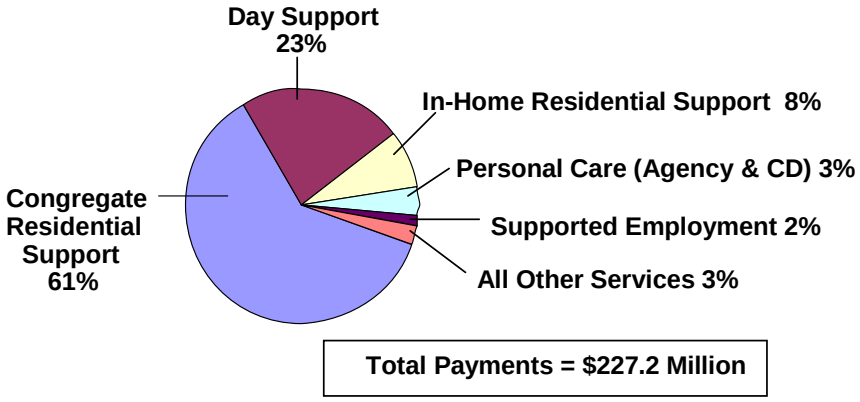
In the last year, Matt has flourished in the day support program. He received a dynavox communication box that he operates with his knee. Matt has gone from making simple life need requests to interacting and joking with his peers and staff. He has friends and always comes to the center happy and laughing. He is able to go out regularly in the community. In addition, he is working to use other adaptive devices to communicate.

Source: Virginia home and community-based service provider.

Figure 3

Mental Retardation Waiver, FY 2004

Percentage of Payments by Service Type



Source: *The FY 2004 Statistical Record of the Virginia Medicaid Program*.

Technology Assisted Waiver. The Technology Assisted Waiver provides in-home care for individuals who are dependent upon technological support; require substantial, ongoing nursing care; and who would otherwise require hospitalization or placement in a specialized care facility. To be eligible for the waiver, adults must depend on a ventilator daily or require prolonged intravenous nutrition, drugs, or peritoneal dialysis. Children must depend on a ventilator daily; require prolonged intravenous nutrition, drugs, or peritoneal dialysis; or have a daily dependency on

other device-based respiratory or nutritional support. In FY 2004, 339 individuals received services through the Technology Assisted Waiver. The cap on the number of individuals that can receive services at any one time through this waiver is 300, and there is currently no waiting list. Case Example 3 profiles an individual receiving services through the Technology Assisted Waiver.

Figure 4 shows the distribution of payments under the Technology Assisted Waiver. Nearly all of the payments provided under this waiver (97 percent) are for private duty nursing services. The remaining three percent of payments are primarily dedicated to respite care services, which consists of private duty nursing.

Case Example 3

Shortly after Sara's birth, she began experiencing breathing difficulties that eventually resulted her needing a tracheotomy. As the weeks passed, Sara was diagnosed with a variety of health and disability conditions that required around-the-clock care. Sara's mother quit work in order to provide her care.

Three years ago, Sara was determined eligible to receive services through either the MR Waiver or the Technology Assisted Waiver. Because there was a waiting list for the MR Waiver, Sara's family chose to receive the Technology Assisted Waiver rather than place her in an ICF/MR or hospital.

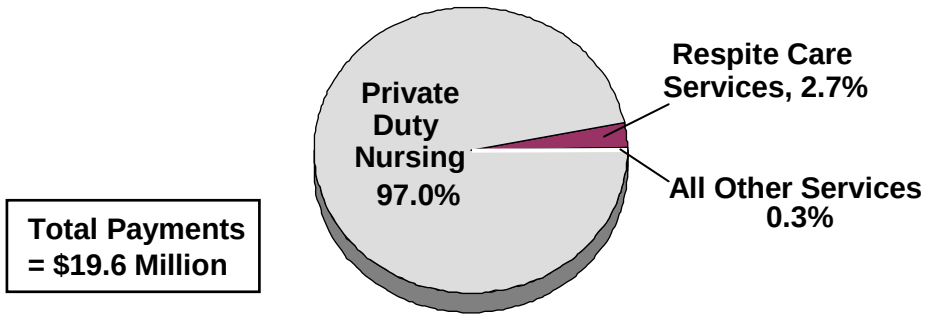
Sara now is in the fourth grade. She has remained at home with her family and receives ten hours a day of nursing services through the Technology Assisted Waiver. Her parents now involve her in community activities and have access to respite services when family emergencies arise, or when they need a brief reprieve.

Source: Based on case studies included in the *Home and Community-based Services for People with Disabilities Medicaid Waiver Services Guide*: Norfolk Endependence Center.

Figure 4

Technology Assisted Waiver, FY 2004

Percentage of Payments by Service Type



Source: *The FY 2004 Statistical Record of the Virginia Medicaid Program.*

AIDS Waiver. The AIDS waiver provides home and community-based care to individuals with acquired immunodeficiency syndrome (AIDS) or who are HIV-positive and symptomatic, and who are at risk of being admitted to a nursing facility or hospital. The number of individuals receiving services through the AIDS waiver has declined in recent years, in part because improved treatment of AIDS has led to fewer individuals qualifying for the waiver. In FY 2004, 274 individuals received services through the AIDS Waiver. The cap on the number of individuals permitted to receive services through this waiver at any given time is 519 and has not been met. Case Example 4 profiles an individual receiving services through the AIDS waiver.

Case Example 4

When Jeff was 39 years old, he was diagnosed with AIDS. After a period of time, he was no longer able to work because of health-related issues. Jeff was screened by his local Department of Health and was determined to need nursing home care. Jeff wanted to continue to live with his family and opted to receive AIDS Waiver services instead of being admitted to a nursing home.

Jeff has reduced gross motor skills and needs daily personal care services. The AIDS Waiver allows Jeff to hire an attendant to assist him for three hours every evening with his personal care needs. The AIDS Waiver also provides skilled nursing services to assist with the administration of medications, including one that must be provided intravenously, and to monitor his health.

Jeff's health has stabilized, and he is now working at his old job part time. His wages are low enough to continue his AIDS Waiver eligibility. Jeff receives some health insurance through his employer, so Medicaid is Jeff's secondary insurance program.

Source: Based on one of several case studies included in the *Home and Community-based Services for People with Disabilities Medicaid Waiver Services Guide*: Norfolk Endependence Center.

Figure 5 shows the allocation of payments provided through the AIDS Waiver in FY 2004. The largest percentage of payments was made for personal care services, followed by case management services and respite care. As mentioned previously, respite care services are often personal care provided on a temporary basis.

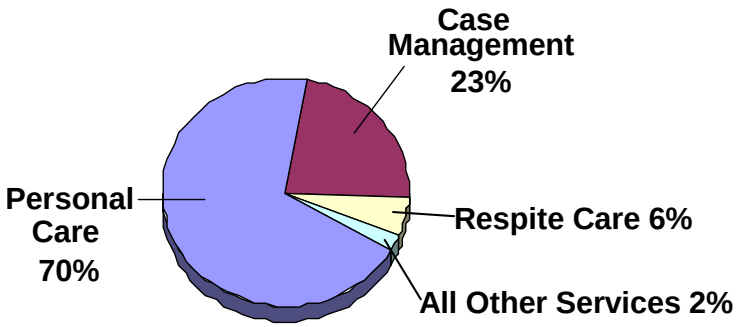
Individual and Family Developmental Disabilities Support Waiver. The DD Waiver is available for eligible individuals six years of age and older who have a related condition and who meet the criteria for placement in an ICF/MR, but do not have a diagnosis of mental retardation. Examples of developmentally disabled individuals include persons with autism, cerebral palsy, or brain injuries. In FY 2004, 270 individuals received services through the DD Waiver. During the current biennium, the General Assembly increased the number of slots for the DD Waiver to 428. As of June 2005, 264 individuals were on the waiting list for the DD Waiver, with 57 of those individuals receiving services through the ED/CD Waiver. Case Example 5 profiles an individual receiving services through the DD Waiver.

Figure 6 shows the allocation of payments through the DD Waiver in FY 2004. The largest share of DD waiver payments (47 percent) were made for personal

Figure 5

AIDS Waiver, FY 2004

Percentage of Payments by Service Type



Total Payments = $0.6 Million

Source: *The FY 2004 Statistical Record of the Virginia Medicaid Program*.

Case Example 5

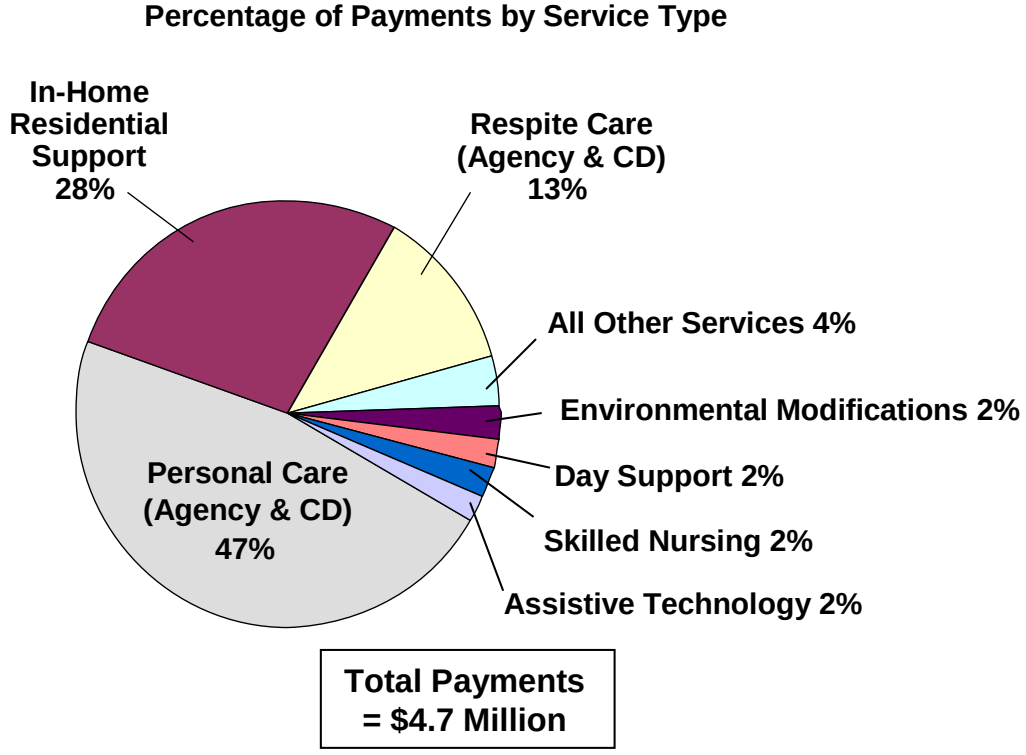
When Steve was a toddler, his parents noticed that his developmental milestones were different from their first two children. At the age of three, Steve was diagnosed with autism. He began special education preschool services. However, as Steve has gotten older, his siblings have had a more difficult time interacting with him.

When Steve was six-years old, he was determined to be eligible for the DD Waiver. After a year of receiving services, the family had an improved routine. Steve's behaviors were less challenging, and he began to learn new independent living skills. Alarms were installed on the entrances to the home so that his family would know immediately if he went outside. In-home residential support trained Steve in organizational, behavioral, grooming, and eating skills. These in-home services were scheduled so that he received fewer services on school days and more services on non-school days.

Steve and his parents are preparing for their second year of DD Waiver services; along with his support coordinator and service providers, they are reviewing the success of the current services and will be determining if the same, additional, or different services are needed.

Source: Based on case studies included in the *Home and Community-based Services for People with Disabilities Medicaid Waiver Services Guide*: Norfolk Endependence Center.

Figure 6
Individual and Family Developmental Disabilities and Support Waiver, FY 2004



Source: *The FY 2004 Statistical Record of the Virginia Medicaid Program*.

care services, followed by in-home residential support services (28 percent). Respite care made up the third largest category of payments (13 percent). The remaining 12 percent of payments were made across a variety of services, including environmental modifications, day support, skilled nursing, and assistive technology.

MEDICAID HOME AND COMMUNITY-BASED SERVICES ARE USUALLY PREFERRED OVER INSTITUTIONAL CARE WHEN APPROPRIATE

There are several reasons why home and community-based services are beneficial and usually preferred over institutional care. These services are cost effective, allow for individual preference, and facilitate compliance with the *Olmstead* decision. Thus, the use of HCB services, whenever appropriate, is a good choice from an economic, sociological, and legal standpoint.

Cost-Effectiveness

HCB services are typically more cost effective than institutional care, and their increased use could yield additional State savings for those recipients who would likely end up in an institution. (Multiple studies have suggested that some individuals who receive HCB services never would actually be admitted to an institution.) Yet, Medicaid still seems to have an "institutional bias" that dates back to before 1981, when the only long-term care benefit under Medicaid was placement in an institution. Table 3 summarizes the per-capita costs of Medicaid recipients who received HCB services versus those who were placed in institutions.

Table 3

Average Per-Capita Costs of Medicaid Waiver Recipients versus Institutionalized Recipients

	Waiver Recipients	Institutionalized Recipients
All Waiver Recipients	$28,473	$41,809
Mental Retardation and Developmentally Disabled	47,537	156,128
Elderly and Disabled	14,823	34,589

Source: JLARC staff analysis of data in the *FY2004 Statistical Record of the Virginia Medicaid Program,* p.8-60.

Per-Capita Cost of Home and Community-Based Care. According to the *FY 2004 Statistical Record of the Virginia Medicaid Program*, the average annual cost of long-term care and mental health services was about $28,473 per HCB waiver participant. However, there were substantial differences in costs among HCB waiver target populations. For example, the average cost of HCB waiver services for people with mental retardation was $47,537 per participant while waiver services for seniors or younger persons with non-developmental disabilities were an average cost per participant of $14,823. Two primary factors likely explain the differences in HCB waiver costs among target population groups: the intensity of the services required and the extent to which other State plan services can meet the needs of the target population, which reduces the costs of the services furnished through HCB waiver programs. Historically, the costs of supporting individuals with mental retardation through HCB waiver programs have been well above costs of supporting other target populations, because a relatively high percentage of waiver participants with mental retardation have been receiving residential services, which tend to be very time intensive.

Per-Capita Cost of Institutional Care Is More Expensive. Comparable data from the *FY 2004 Statistical Record* on Medicaid payments for institutional care recipients indicate that per-capita costs were considerably higher for individuals in institutions compared to those receiving waiver services. Among all Medicaid recipients in nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs) combined, the average per-capita cost was about $41,809. But again, distinguishing the average costs of people with mental retardation from everyone else is more revealing. The average cost of ICF/MR services for people with

mental retardation or developmental disabilities was $156,128 per participant. The average per-capita cost of nursing facilities for everyone else was about $34,589 per participant. Overall, data from the *FY 2004 Statistical Record* indicate that the per-capita cost of HCB waiver programs is about one-third to one-half of the per-capita cost of institutional care.

Individual Preference

Persons with disabilities and their families share goals that are similar to everyone else's, such as maintaining control over their daily lives and activities in settings that are integrated with the rest of society. In recent decades, advocacy groups have been working to transition people with disabilities from institutions to community settings in order to help them fulfill these goals. Case Example 6 illustrates an individual's preference for community-based care over institutional placement.

Case Example 6

When Fred was a child, he was diagnosed with mental retardation. He was placed in an intermediate care facility for the mentally retarded (ICF/MR), where he lived for 30 years. When home and community-based services became an option for Fred through the Mental Retardation Waiver, he chose to live in the community rather than staying in the ICF/MR facility.

Through the help of the community services board and local disability organizations, Fred was able to transition from the facility to his own apartment. Fred began receiving residential services through the MR Waiver to help establish his household, plan meals, manage his budget, and do laundry. He also made use of supported employment services. Eventually, he was able to reduce his use of some residential services. Instead, personal care services helped him with cooking, hygiene, and household cleaning.

Fred now lives in an apartment and works in a nearby small office complex. He gets to work using public transportation and walks to the neighborhood fast food restaurant for breakfast. Fred now has more control over his life and recently transitioned to consumer-directed services that are available through the MR Waiver.

Source: Based on case studies included in the *Home and Community-based Services for People with Disabilities Medicaid Waiver Services Guide*: Norfolk Endependence Center.

Olmstead Decision

The U.S. Supreme Court's 1999 *Olmstead* decision (Exhibit 2) requires states to offer individuals a choice between institutional and community-based settings. The Court noted that institutional placement perpetuates assumptions that persons so isolated are incapable or unworthy of participating in community life. The Court also noted that confinement in an institution severely diminishes the eve-

Exhibit 2

Olmstead Decision

The Olmstead decision was the result of a lawsuit brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs lived in state-run institutions, despite the fact that their treatment professionals had determined that they could be appropriately served in a community setting. The plaintiffs asserted that continued institutionalization was a violation of their right under the Americans with Disabilities Act (ADA) to live in the most integrated setting appropriate.

In June 1999, the U.S. Supreme Court ruled in the Olmstead case that it is a violation of the ADA for states to discriminate against people with disabilities by providing services in institutions when the individual could be served more appropriately in a community-based setting. The decision affirmed that states are required to provide community-based services for people with disabilities if treatment professionals determine that it is appropriate, the affected individuals do not object to such placement, and the state has the available resources to provide community-based services.

The Court suggested that states could establish compliance with the ADA by having: (1) a comprehensive, effective working plan for placing qualified people in less restrictive settings, and (2) a waiting list for community-based services that ensures people can receive services and be moved off the list at a reasonable pace.

The Olmstead Decision: Implications for Medicaid, Kaiser Commission on Medicaid and the Uninsured, March 2000. *Understanding Medicaid Home and Community Services: A Primer,* U.S. Department of Health and Human Services, October 2000.

ryday activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. Case Example 7 profiles a Medicaid waiver recipient who is an active member in her community, despite being severely disabled.

Pressure from advocacy groups and the need to comply with the *Olmstead* decision have pushed states to consider community-based care as a viable alternative to institutional care and to provide services to more Medicaid recipients in community settings. Many states have also created comprehensive long-term care plans that include efforts to transition or maintain people in community-based settings.

Case Example 7

One Medicaid Elderly and Disabled / Consumer Directed waiver recipient has been wheelchair-bound for over 20 years because of a spinal cord injury. She strongly prefers receiving home and community-based care over institutional placement. She says that staying at home and in the community provides her with a higher quality of life, allowing her to be involved as a volunteer with a local non-profit organization and as a part-time employee as an advocate with a Center for Independent Living.

Source: Virginia home and community-based waiver recipient

VIRGINIA RELIES LESS ON HOME AND COMMUNITY-BASED CARE, BUT MAY FACE GREATER DEMAND IN THE FUTURE

Virginia provides less Medicaid home and community-based care than most other states. In FY 2004, Virginia ranked 48th among all states for spending on total long-term care, and Virginia is below average in terms of the proportion of spending on long-term care dedicated to home and community-based services. This relatively low level of spending should be evaluated in light of the expectation that demand for long-term care services will increase in the future.

Virginia Spends Relatively Little on Medicaid Community-Based Services

According to data compiled from quarterly expenditure reports that all states submit to the Centers for Medicare and Medicaid Services (CMS-64 reports), Virginia spends less per capita on long-term care services as compared to most other states. In FY 2004, Virginia ranked 48th in terms of total Medicaid long-term care expenditures, when controlling for the size of states on the basis of their populations (Table 4). When per-capita long-term care expenditures are disaggregated by institutional care and community-based care services, Virginia still ranks relatively low compared to other states across all services.

Further, compared to other states, a relatively high percentage of Virginia's Medicaid long-term care expenditures goes toward institutional services rather than toward community-based services (Table 5). This "institutional bias" also appears when disaggregating the data and examining Medicaid long-term care dollars spent on services for the aged and disabled separately from those for people with mental retardation and developmental disabilities

Table 4

Total Medicaid Long-Term Care Expenditures by State, FY 2004

RANK	STATE	EXPENDITURES	PER CAPITA
1	New York	$16,023,257,966	$833.37
2	Connecticut	2,029,152,858	579.26
3	Washington DC	304,664,527	550.93
4	Minnesota	2,458,269,319	482.01
5	Rhode Island	518,900,332	480.46
6	Pennsylvania	5,886,320,207	474.47
7	North Dakota	285,619,852	450.50
8	Massachusetts	2,857,649,658	445.39
9	Maine	583,025,664	442.69
10	Alaska	282,755,138	431.69
11	Vermont	248,549,334	400.24
12	Ohio	4,547,335,391	396.84
13	West Virginia	688,717,715	379.46
14	Nebraska	616,759,486	353.04
15	New Hampshire	450,256,605	346.62
16	Wisconsin	1,888,642,959	342.83
17	New Jersey	2,912,344,186	334.83
18	Wyoming	166,266,003	328.59
19	New Mexico	625,221,686	328.55
20	Iowa	946,365,043	320.37
21	Delaware	263,869,190	317.91
22	Montana	285,861,866	308.71
23	North Carolina	2,495,763,958	292.21
24	Louisiana	1,304,396,590	288.90
25	Kansas	778,277,226	284.56
26	Missouri	1,631,643,043	283.57
27	Arkansas	778,807,563	283.00
28	Indiana	1,764,722,664	282.94
29	South Dakota	217,663,414	282.68
30	Mississippi	791,011,129	272.57
31	Maryland	1,488,922,930	267.89
32	Oklahoma	922,572,069	261.87
33	Washington	1,583,408,395	255.26
34	Illinois	3,226,251,125	253.78
35	Tennessee	1,492,355,875	252.94
36	Kentucky	1,043,865,522	251.84
37	Georgia	2,144,581,088	242.90
38	Alabama	1,076,206,730	237.57
39	Michigan	2,400,870,484	237.43
40	Hawaii	298,665,715	236.66
41	Oregon	808,216,261	224.88
42	South Carolina	917,389,968	218.53
43	Idaho	304,062,224	218.28
44	Florida	3,456,536,002	198.69
45	Colorado	910,262,454	197.84
46	California	6,732,214,667	187.56
47	Texas	4,077,115,939	181.29
48	**Virginia**	**1,256,467,262**	**168.45**
49	Utah	272,498,708	114.06
50	Nevada	239,553,435	102.64
51	Arizona	30,946,041	5.39

Source: Burwell, B., Sredl, K., and Eiken, S. *Medicaid Long Term Care Expenditures in FY 2004.* Cambridge, Mass.: Medstat, May 2005. Based on CMS-64 reports.

Table 5
Distribution of Medicaid Long-Term Care Expenditures
Institutional vs. Community-Based Services, FY 2004

		Institutional LTC Services		Community-Based Services		
Rank	STATE	Expenditures	% of Total Medicaid LTC dollars	Expenditures	% of Total Medicaid LTC dollars	Total LTC Expenditures
1	Oregon	$238,642,419	29.5	569,573,842	70.5	$808,216,261
2	New Mexico	202,759,233	32.4	422,462,453	67.6	$625,221,686
3	Alaska	107,091,559	37.9	175,663,579	62.1	$282,755,138
4	Vermont	105,193,772	42.3	143,355,562	57.7	$248,549,334
5	Minnesota	1,085,121,954	44.1	1,373,147,365	55.9	$2,458,269,319
6	Washington	717,293,415	45.3	866,114,980	54.7	$1,583,408,395
7	Wyoming	77,461,323	46.6	88,804,680	53.4	$166,266,003
8	Colorado	468,695,862	51.5	441,566,592	48.5	$910,262,454
9	Maine	309,491,556	53.1	273,534,108	46.9	$583,025,664
10	Kansas	413,492,811	53.1	364,784,415	46.9	$778,277,226
11	California	3,732,842,761	55.4	2,999,371,906	44.6	$6,732,214,667
12	New York	9,062,604,672	56.6	6,960,653,294	43.4	$16,023,257,966
13	Rhode Island	300,430,394	57.9	218,469,938	42.1	$518,900,332
14	Utah	159,832,083	58.7	112,666,625	41.3	$272,498,708
15	Idaho	180,156,653	59.2	123,905,571	40.8	$304,062,224
16	Wisconsin	1,144,382,922	60.6	744,260,037	39.4	$1,888,642,959
17	West Virginia	421,398,257	61.2	267,319,458	38.8	$688,717,715
18	North Carolina	1,528,587,102	61.2	967,176,856	38.8	$2,495,763,958
19	New Hampshire	278,375,771	61.8	171,880,834	38.2	$450,256,605
20	Maryland	927,422,308	62.3	561,500,622	37.7	$1,488,922,930
21	Connecticut	1,270,161,843	62.6	758,991,015	37.4	$2,029,152,858
22	South Dakota	137,169,800	63.0	80,493,614	37.0	$217,663,414
23	Oklahoma	583,480,183	63.2	339,091,886	36.8	$922,572,069
24	Hawaii	190,172,112	63.7	108,493,603	36.3	$298,665,715
25	Texas	2,607,607,122	64.0	1,469,508,817	36.0	$4,077,115,939
26	Montana	183,443,987	64.2	102,417,879	35.8	$285,861,866
27	Missouri	1,053,105,605	64.5	578,537,438	35.5	$1,631,643,043
28	Massachusetts	1,845,670,334	64.6	1,011,979,324	35.4	$2,857,649,658
29	Nebraska	420,521,354	68.2	196,238,132	31.8	$616,759,486
30	**Virginia**	**858,154,652**	**68.3**	**398,312,610**	**31.7**	**$1,256,467,262**
31	New Jersey	1,992,728,087	68.4	919,616,099	31.6	$2,912,344,186
32	Iowa	651,772,754	68.9	294,592,289	31.1	$946,365,043
33	South Carolina	636,749,438	69.4	280,640,530	30.6	$917,389,968
34	Nevada	167,396,759	69.9	72,156,676	30.1	$239,553,435
35	Kentucky	734,073,010	70.3	309,792,512	29.7	$1,043,865,522
36	Delaware	187,294,874	71.0	76,574,316	29.0	$263,869,190
37	Michigan	1,723,158,272	71.8	677,712,212	28.2	$2,400,870,484
38	Indiana	1,294,277,812	73.3	470,444,852	26.7	$1,764,722,664
39	Illinois	2,367,156,736	73.4	859,094,389	26.6	$3,226,251,125
40	Florida	2,559,563,015	74.0	896,972,987	26.0	$3,456,536,002

(Table continues, next page)

Table 5 (Continued)
Distribution of Medicaid Long-Term Care Expenditures
Institutional vs. Community-Based Services, FY 2004

		Institutional LTC Services		Community-Based Services		
Rank	STATE	Expenditures	% of Total Medicaid LTC dollars	Expenditures	% of Total Medicaid LTC dollars	Total LTC Expenditures
41	Alabama	803,219,787	74.6	272,986,943	25.4	$1,076,206,730
42	Arizona	23,172,901	74.9	7,773,140	25.1	$30,946,041
43	Georgia	1,612,270,970	75.2	532,310,118	24.8	$2,144,581,088
44	North Dakota	221,295,238	77.5	64,324,614	22.5	$285,619,852
45	Louisiana	1,012,436,635	77.6	291,959,955	22.4	$1,304,396,590
46	Pennsylvania	4,571,703,178	77.7	1,314,617,029	22.3	$5,886,320,207
47	Ohio	3,563,619,068	78.4	983,716,323	21.6	$4,547,335,391
48	Arkansas	611,515,100	78.5	167,292,463	21.5	$778,807,563
49	Tennessee	1,233,979,804	82.7	258,376,071	17.3	$1,492,355,875
50	Washington DC	269,019,546	88.3	35,644,981	11.7	$304,664,527
51	Mississippi	749,686,055	94.8	41,325,074	5.2	$791,011,129

Note: Institutional services include nursing homes services and ICF-MR services. Community-based services include HCB waiver services, personal care services and Medicaid home health.

Source: Burwell, B., Sredl, K., and Eiken, S. *Medicaid Long Term Care Expenditures in FY 2004*. Cambridge, Mass.: Medstat, May 2005.

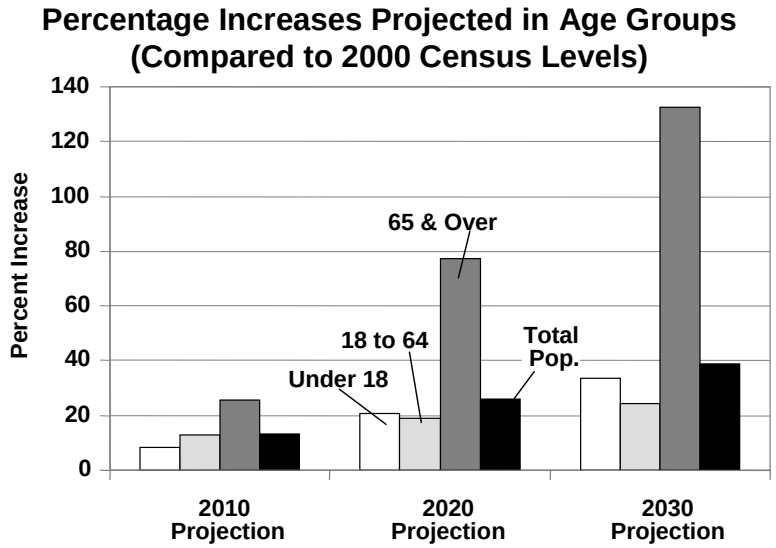
Expected Increases in Demand for Home and Community-Based Services

The populations served by Medicaid home and community-based care waivers are expected to increase, which will likely lead to an increased demand for these services. Virginia, like the rest of the states, will experience an aging trend in its population over the next several decades. Figure 7 shows that individuals 65 and older are expected to be the fastest growing population group in Virginia. By 2010, the U.S. Census Bureau projects this population will have increased at nearly twice the rate of the overall State population, and by 2030, more than three times that of Virginia's population.

This faster growth rate will lead to the population of individuals 65 and older making up a larger portion of the overall State population. In 2000, those 65 and older made up 11.2 percent of the population in Virginia. However, by 2030 the Census Bureau projects this age group to make up 18.8 percent of the total State population. As demand for all services for the elderly increases, it is likely that the demand for home and community-based long-term care services, such as personal care, will increase as well.

However, it is not only the demand for services to the elderly that is expected to increase. As medical technology has improved, individuals with mental retardation and developmental disabilities, as well as medically fragile individuals, are living longer. Providers in Virginia indicated that while developmentally disabled individuals previously only lived into their 20s or 30s, increasingly these individuals are living into their 40s, 50s, and 60s. For example, the average life expectancy for individuals with mental retardation is now 67 years for females and

Figure 7



Source: JLARC staff analysis of data from the U.S. Census Bureau.

63 years for males. Individuals with Down syndrome provide an even more striking example. From 1983 to 1997, the average life expectancy for a person with Down syndrome doubled from 25 to 49 years of age. Today, females with Down syndrome are expected to live an average of 57 years and males an average of 54 years.

Because individuals with disabilities are living longer, they require services for a longer period of time. In addition, these individuals are outliving their parents. While previously many parents planned to care for their disabled child throughout his or her life, this may no longer be feasible. As parents of disabled individuals get older, they are seeking alternatives, such as the Medicaid waiver system, to care for their disabled adult children. (See Case Example 8.)

Further, parents of young children with developmental disabilities are increasingly more knowledgeable about the Medicaid system and are seeking placement for their children in the system at a younger age. Because disabled individuals usually receive waiver services for the duration of their life, their placement in the system at a younger age may result in them being in the system for a longer period of time.

Case Example 8

Belle began receiving day support services in 2002 at 40 years of age. Never having attended school or received any other formal training, she was entirely cared for by her aging mother and a housekeeper. When the mother was placed in a nursing home and the housekeeper was unable to provide total care, Belle became eligible for MR waiver services.

Source: Virginia Day Support Provider

STUDY MANDATE AND JLARC REVIEW

Although the overall level of Medicaid spending on home and community-based services has increased in Virginia over the past decade, this spending has been largely driven by increases in the number of individuals receiving these services. In fact, the Medicaid reimbursement rates for most HCB services have changed very little over the past decade. Many services have received only minor rate adjustments over this period, and some services have had no adjustments to their rates over this period.

Because of the State's ad-hoc approach to reimbursement rates, providers of waiver services and recipients are concerned that the Medicaid rates for waiver services are too low and may translate into inadequate access to care for eligible recipients. This concern was the motivation for language in the 2005 Appropriation Act directing JLARC to report on the adequacy of Medicaid reimbursement rates for home and community-based care services and the impact of reimbursement levels on access to care for the Medicaid recipient population (Appendix A).

Research Activities

JLARC staff conducted a variety of research activities during the course of this study, including interviews with relevant State agencies, advocacy groups, providers, and recipients to determine the nature of the concerns regarding reimbursement rates and access to services. Staff analyzed the distribution of Medicaid waiver recipients across the State to determine whether concerns regarding access were supported by data. JLARC staff also estimated the cost of providing services using different assumptions and used them to assess the adequacy of Medicaid rates. In addition, JLARC staff compared Virginia's expenditures on HCB services and the rates for these services to those of other states, and conducted a literature review.

Structured Interviews. To better understand the perceived problems with Medicaid reimbursement rates and their potential impact on access to services, JLARC staff conducted structured interviews with State agencies, advocacy groups for Medicaid waiver providers and recipients, service providers, and Medicaid waiver recipients. Interviews with advocacy groups tended to cover a variety of waiver services, whereas interviews conducted with service providers across the State focused on the top six services in terms of total Medicaid waiver payments. In addition to the interviews, providers also submitted case studies to JLARC staff to illustrate the benefits of providing waiver services to eligible individuals, both in terms of keeping them out of institutions and improving their quality of life.

Recipient Distribution Analysis. To determine whether expected widespread regional differences in access to waiver services exist, JLARC staff analyzed Medicaid waiver recipients on a locality basis using data available from the Department of Medical Assistance Services (DMAS). This analysis was conducted at the locality level and then aggregated for presentation at the planning district commis-

sion (PDC) level, so that any regional trends would be more apparent. The analysis was conducted across four fiscal years, although only the most recent (FY 2004) is presented in this report.

Cost Analysis of Providing Services. To assess the adequacy of current Medicaid reimbursement rates, JLARC staff estimated the cost of providing services using different assumptions and compared these alternative estimates to the existing rates. In particular, JLARC staff compared the existing rates to illustrative costs of providing services using assumptions about the wage rates for direct care staff. One approach was based on compensating direct care staff at a level that is comparable to State and nursing home employees in similar positions, and another was based on providing a living wage for direct care staff. In developing these cost estimates, JLARC also reviewed cost analyses that were developed by two other states for services that were comparable to those in the JLARC review. These cost analyses were supplemented by information in cost reports provided by a limited number of Virginia service providers. JLARC staff also compared how rates have changed compared to different measures of inflation over the past ten years.

Comparisons with Other States. JLARC staff assessed how Virginia compares to other states both in terms of total expenditures on HCB services and reimbursement rates for these services. To compare how Virginia ranks in terms of total expenditures, JLARC staff reviewed federal CMS data that ranked all 50 states and the District of Columbia in terms of total long-term expenditures and the distribution of these expenditures between institutional care and HCB services. JLARC also conducted detailed Medicaid rate comparisons among several states in the Southeast and mid-Atlantic region for a number of services covered in the review.

Literature Review. JLARC staff reviewed the recent literature about Medicaid home and community-based services, which included useful background information and statistics.

Report Organization

JLARC staff findings regarding the adequacy of current Medicaid reimbursement rates for HCB services are mixed. Chapter II discusses that in recent years, expected discrepancies in the geographic distribution of Medicaid recipients of HCB services have not occurred. This finding indicates that the expected widespread geographic disparities in access to HCB services are not occurring because of Medicaid reimbursement rates. However, other factors besides the reimbursement rates probably affect this outcome. In addition, there still may be instances in which individuals have trouble accessing services.

Chapter III examines the reimbursement rates and the evidence supporting providers' claims that rates are problematic. Reimbursement rates for HCB services have not been routinely adjusted for inflation, and the rates for services provided in an individualized setting appear to be low when compared to other states and to estimated costs that would allow providers to pay direct care workers either a competitive or living wage. In addition, while the rates for most services receive a Northern

Virginia locality adjustment, this adjustment is not provided for all services. Because these issues may warrant further consideration, Chapter III provides several options for addressing these issues. Chapter III also indicates that the rate structure for services provided in a group setting is especially problematic, and that further review of alternative rate structures is needed.

II. Geographic Distribution of Medicaid Waiver Recipients and Issues of Access

The study mandate directs JLARC to examine "the impact of reimbursement levels on access to care for the Medicaid recipient population." As shown in Chapter I, Virginia tends to pay for less Medicaid community-based care than most other states. Further, providers have frequently said that current Medicaid reimbursement rates could result in problems of access. Therefore, one way to assess the possible effects of current rates on access is to examine first whether there are lower levels of service in some parts of the State.

To determine whether some parts of the State tend to have relatively lower numbers of Medicaid recipients receiving community-based services compared to others, JLARC staff examined two frequently voiced concerns:

- Do the Southwestern and Southside regions of the State tend to have relatively lower proportions of their populations receiving Medicaid home and community-based services? Therefore, is there less access to these services in these regions?

- Do rural localities (localities with lower population density) tend to have relatively lower proportions of Medicaid recipients receiving home and community-based services compared to urban localities (localities with higher population density)? Therefore, do Medicaid recipients in rural localities appear to have less access to these services?

JLARC staff evaluated these concerns using data from the Department of Medical Assistance Services (DMAS) on services received by Medicaid waiver recipients identified according to their localities from FY 2001, 2002, 2003, and 2004. The DMAS data do not indicate that these concerns are warranted. However, this finding requires several qualifiers. First, the geographic distribution of Medicaid waiver recipients may reflect factors other than reimbursement rates. For example, the allocation of Mental Retardation (MR) waiver slots may have a strong effect on the geographic distribution of Medicaid recipients of MR waiver services. Also, this finding does not change the fact that the overall availability of services in Virginia may be relatively low compared to other states (based on expenditure data). Further, this finding does not mean that individuals who need services can always find them or that it is not more difficult to find services in certain areas.

JLARC staff were also alerted by providers to other issues that may affect access of Medicaid waiver recipients to services. The one most frequently mentioned was the patient co-payment (referred to as "patient pay") that deters some eligible individuals or their caretakers from seeking community-based services.

CONCERNS ABOUT REDUCED ACCESS TO WAIVER SERVICES IN SOME AREAS DO NOT APPEAR WARRANTED

JLARC staff examined the geographic distribution of each of the six largest service categories (personal care, respite care, congregate residential, in-home residential, day support, and private duty and skilled nursing care). The geographic distribution of the remaining services was also examined by adding the dollar amounts spent for these services for Medicaid waiver recipients in each locality. The results using DMAS data from FY 2004 are reported. Data from other years (FY 2001, 2002 and 2003) were also examined, with nearly identical results as those from FY 2004. The distribution of recipients of the six major services and payments for the other remaining services for FY 2004 on the individual locality level are shown in Appendix C.

For each of the services, JLARC staff standardized the data to control for different local population levels. (Otherwise, Fairfax County would always have the largest number of recipients and Highland County the smallest, due solely to the scale of their operation.) For personal care, respite care, and private duty and skilled nursing care services, the primary variable examined was the number of recipients per 1,000 local population under the federal poverty level. For congregate residential, in-home residential, and day support services, the key dependent variable was the number of recipients per 1,000 total local population, because most individuals qualifying for these services on a functional basis would also qualify on a financial basis. For the other services, the primary variable was dollars spent on these other services per capita (based on total local population). Other ways of representing and standardizing the variables were also examined, but produced essentially identical results.

Personal Care and Respite Care

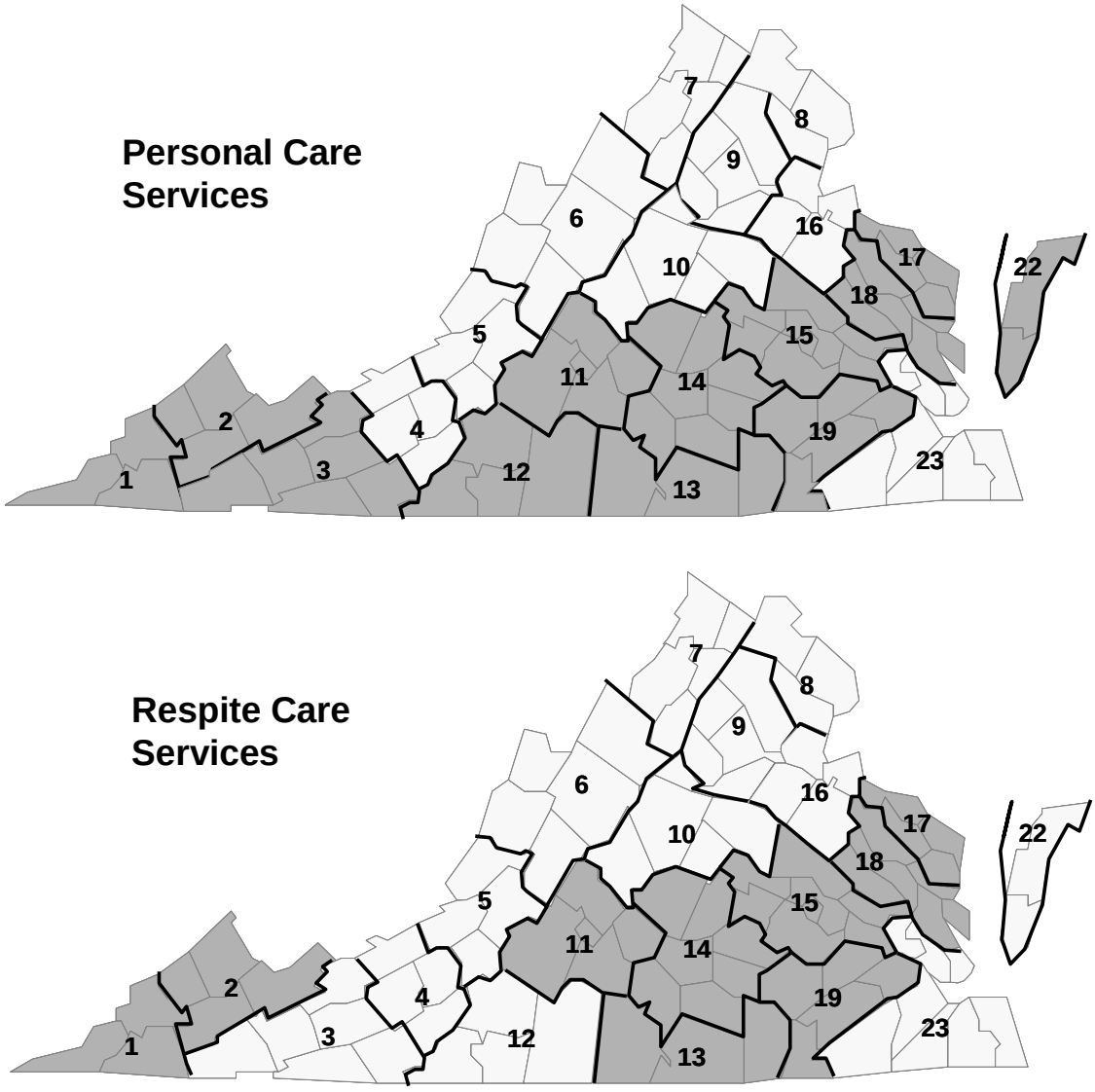
Personal care and respite care (for personal care services) are the most frequently used Medicaid waiver services. They are used primarily by recipients of the E&D waiver, which is the largest Medicaid waiver in terms of recipients. The maps in Figure 8 show that, when controlling for poverty population and summarizing the local data on the planning district commission (PDC) level, there is little indication that Medicaid waiver recipients in the Southwestern and Southside regions have substantially less access to personal care and respite care services. In fact, the maps show that in many Southwestern and Southside PDCs, the proportions of the local poverty populations receiving these services tend to be higher than the statewide averages (which are 19.22 personal care recipients and 6.22 respite care recipients per 1,000 people under the poverty level). Consequently, the data on personal care and respite care do not appear to support concerns about reduced access in the Southwestern and Southside regions of the State.

Figure 8
Geographic Distribution of Services

Proportions of local poverty population that are Medicaid recipients receiving services

Above statewide average

At or below statewide average



Key to Planning Districts

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4. New River Valley
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23. Hampton Roads

Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

Similarly, DMAS data were used to evaluate whether Medicaid waiver recipients in rural areas appear to have less access to personal care and respite care services. If there was relatively less access to services in rural localities, then localities with lower population density would have lower proportions of their poverty populations receiving Medicaid personal care and respite care services. "Low population density" localities are defined in this report as those 82 counties in Virginia that have population densities below the statewide average of 188 people per square mile, while "high population density" localities are those 52 Virginia cities and counties having population densities above the statewide average. Likewise, a "lower proportion" of local Medicaid waiver recipients is defined as being below the statewide average of recipients per 1,000 people under the poverty level.

If population density were related to access to services, then most of the localities in Table 6 would fall into the low density–low proportion or the high density–high proportion table cells. However, as shown in Table 6, 52 of the 82 low population density localities have *higher*-than-average proportions of their poverty population receiving Medicaid personal care services. At the same time, 36 of the 52 high population density localities have *lower*-than-average proportions.

Table 6

Distribution of Medicaid Service Recipients by Locality

Proportion of Local Poverty Population[1]	Population Density[2]	
	Low	High
Personal Care Recipients		
High	52	16
Low	30	36
Respite Care Recipients		
High	50	19
Low	32	33

[1]A "high" proportion means that the proportion of a locality's poverty population receiving Medicaid services is greater than the statewide average. The statewide averages are:
19.2 recipients per 1,000 people under the poverty level for personal care
6.2 recipients per 1,000 people under the poverty level for respite care

[2]A "low" population density locality is defined as one having less than the statewide average of 188 people per square mile.

Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

Likewise, the same basic pattern appears when examining data regarding respite care services in Table 6. More localities are in the low density-high proportion and high density–low proportion cells than would be anticipated (which is that the majority of localities would fall into the low–low and high–high cells). Therefore,

the concern that individuals in localities with low population densities have less access to personal care and respite care services is not supported by the data on Medicaid recipients. In fact, the reverse appears to be true. Most localities with lower population densities appear to have proportionately more Medicaid recipients using personal care and respite care services, while most localities with higher population densities tend to have proportionately fewer.

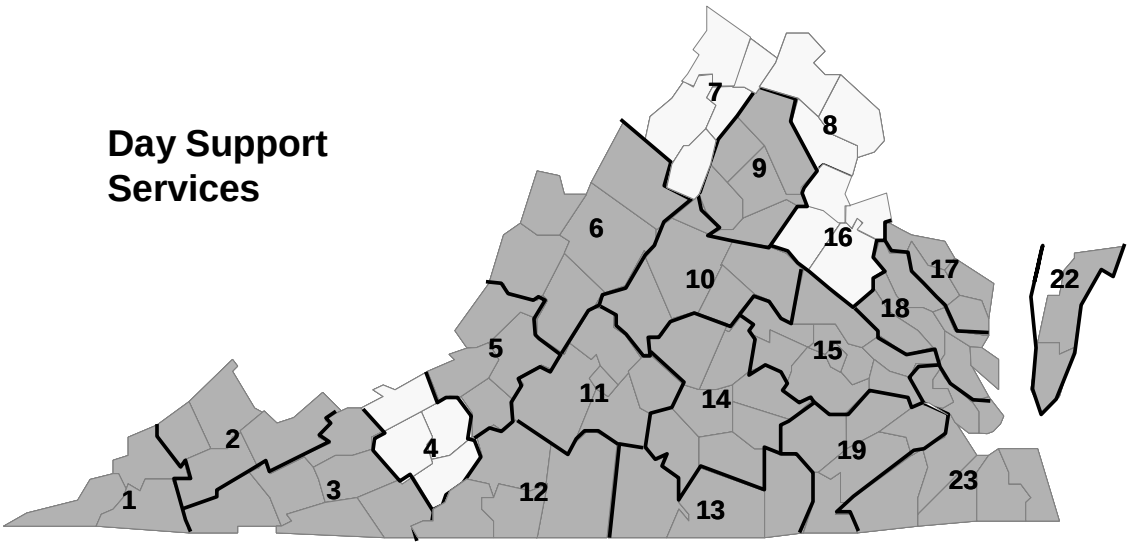
Day Support and Residential Services

The second-largest population served by Medicaid waivers is made up of individuals who have mental retardation or developmental disabilities. This population receives day support services, and congregate or in-home residential services under the Mental Retardation (MR) Waiver or the Individual and Family Developmental Disabilities Support (DD) Waiver. (The DD Waiver does not offer congregate residential services.) JLARC staff standardized the proportion of local recipients of these services by local *total* population rather than local *poverty* population, because most individuals meeting the MR and DD functional eligibility criteria for the waivers also meet the income eligibility criteria. The maps in Figures 9 and 10 show little indication of less access to Medicaid day support and congregate or in-home residential services in the Southwestern or Southside regions, compared to other regions of the State. In particular, the map showing the distribution of day support recipients (Figure 9) indicates that much of the State (including the Southwest and Southside) has an above-average proportion of its population accessing Medicaid day support services, while mostly Northern Virginia localities have below-average proportions.

The data shown in the maps for congregate and in-home residential services (Figure 10) are more complicated to interpret. Because they are both ways to deliver residential services, there may be some substitution of one for the other. Congregate residential services are typically provided to groups of clients, while in-home residential services are provided in a one-on-one setting. The data could indicate that some areas may be below average in the proportion of their population receiving one service while above average in the proportion receiving the other service. Taken together, these maps do not indicate an overall low level of utilization of Medicaid residential services in the Southwestern or Southside regions, compared to other parts of the State.

Figure 9
Geographic Distribution of Services

Proportions of local total population that are Medicaid recipients receiving services



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Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

Likewise, the data do not support the assumption that localities with lower population density tend to have lower proportions of Medicaid recipients receivin day support and residential services. In fact, Table 7 shows that in the case of day support, the opposite is more frequently true, with 50 of 82 low-population-densit localities reporting a high proportion of total local population receiving this service. For congregate and in-home residential services, Table 7 shows that the assumption holds true in 70 localities but not in almost as many (64) others. With so many exceptions, it is clear the data do not support the assumption of a relationship between population density and differences in access to these services.

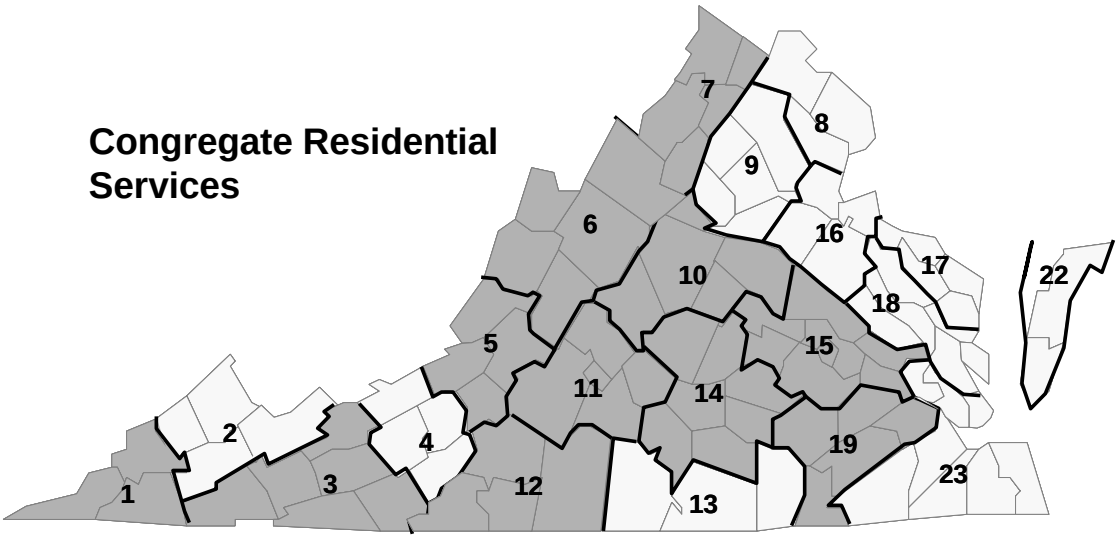
Figure 10
Geographic Distribution of Services

Proportions of local total population that are Medicaid recipients receiving services

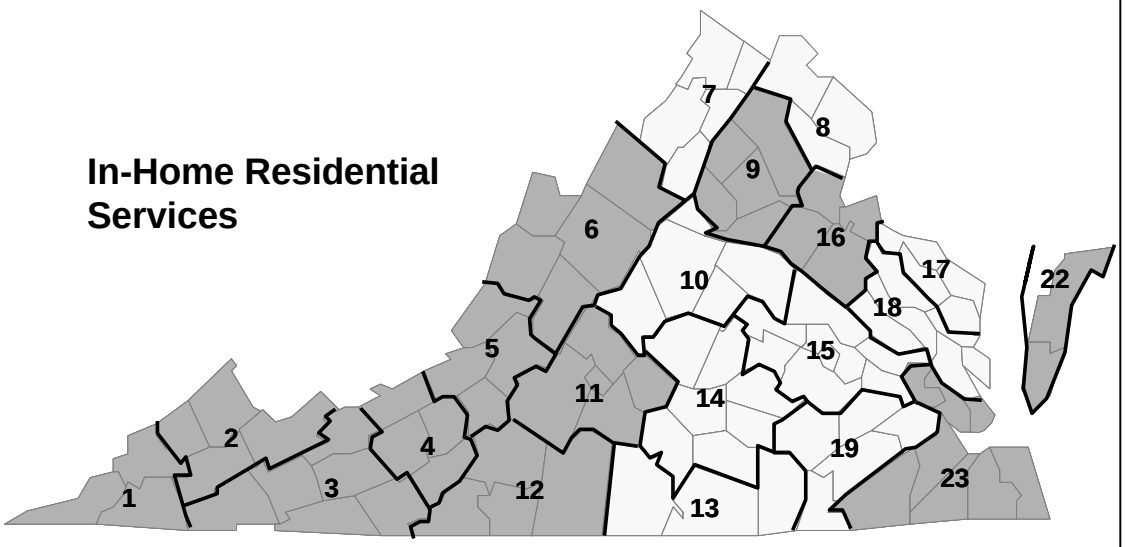
Above statewide average

At or below statewide average

Congregate Residential Services



In-Home Residential Services



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Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

Table 7

Distribution of Medicaid Service Recipients by Locality

Proportion of Local Total Population[1]	Population Density[2]	
	Low	High
Day Support Recipients		
High	50	29
Low	32	23
Congregate Residential Support Recipients		
High	36	24
Low	46	28
In-Home Residential Support Recipients		
High	35	23
Low	47	29

[1]A "high" proportion means that the proportion of a locality's total population receiving Medicaid services is greater than the statewide average. The statewide averages are:
5.8 recipients per 10,000 total population for day support
4.5 recipients per 10,000 total population for congregate residential support
1.7 recipients per 10,000 total population for in-home residential support

[2]A "low" population density locality is defined as one having less than the statewide average of 188 people per square mile.

Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

Private Duty and Skilled Nursing Services

In FY 2004, the vast majority of Medicaid waiver nursing services under the Medicaid waivers went to the 339 Technology Assisted Waiver recipients. This pattern was also the case in other fiscal years. These individuals are dependent upon technological support and require ongoing nursing care, and otherwise would require care in a hospital or nursing facility. The map in Figure 11 may initially appear to suggest that there is less access to private duty and skilled nursing services in the Southwest and the Southside regions of the State because there is less utilization of them in these regions by Medicaid recipients. But when the distribution of the 339 Technology Assisted waiver recipients is examined, the pattern is almost identical to that in Figure 11.

The pattern appears to be driven not as much by the unavailability of nurses in particular regions, but by where the 339 Technology Assisted waiver recipients resided.

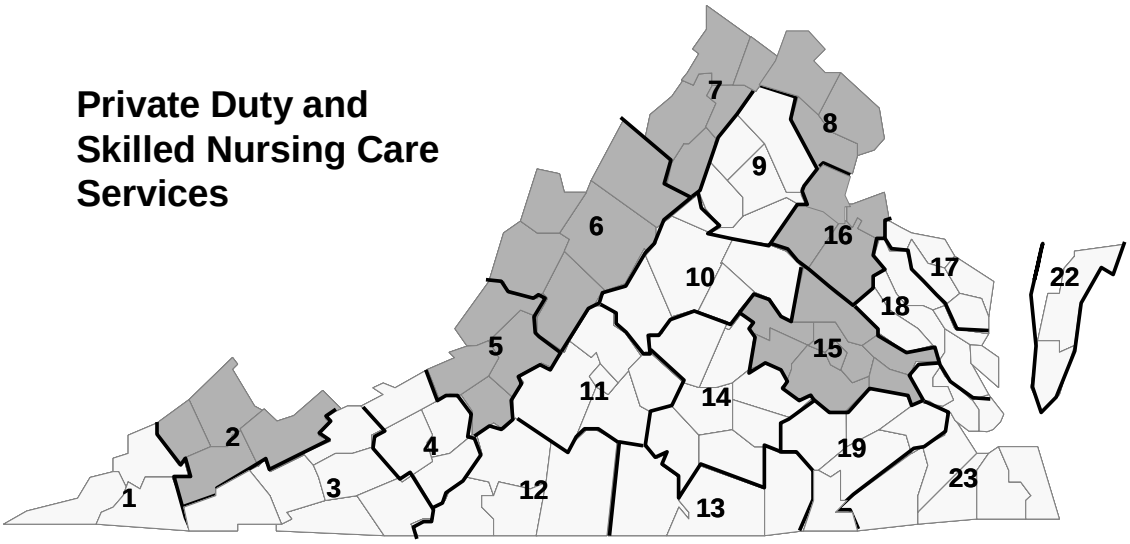
Figure 11
Geographic Distribution of Services

Proportions of local poverty population that are Medicaid recipients receiving services

Above statewide average

At or below statewide average

Private Duty and Skilled Nursing Care Services



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Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

The data again show no support for the notion that localities with lower population density tend to have relatively lower proportions of Medicaid waiver recipients receiving community private duty and skilled nursing services. As shown in Table 8, the localities follow the expected "low-low" and "high-high" pattern in 68 instances, but there are 66 exceptions to the pattern. The observed frequencies in Table 8 come very close to the expected frequencies that would appear if there were no relationship between population density and the proportion of the local population receiving Medicaid private duty and skilled nursing services.

Table 8

Distribution of Medicaid Service Recipients by Locality

Proportion of Local Poverty Population[1]	Population Density[2]	
	Low	High
Private Duty and Skilled Nursing Care Recipients		
High	32	18
Low	50	34

[1]A "high" proportion means that the proportion of a locality's poverty population receiving Medicaid services is greater than the statewide average of 1.2 recipients per 1,000 people under the poverty level.

[2]A "low" population density locality is defined as one having less than the statewide average of 188 people per square mile.

Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

Other Services

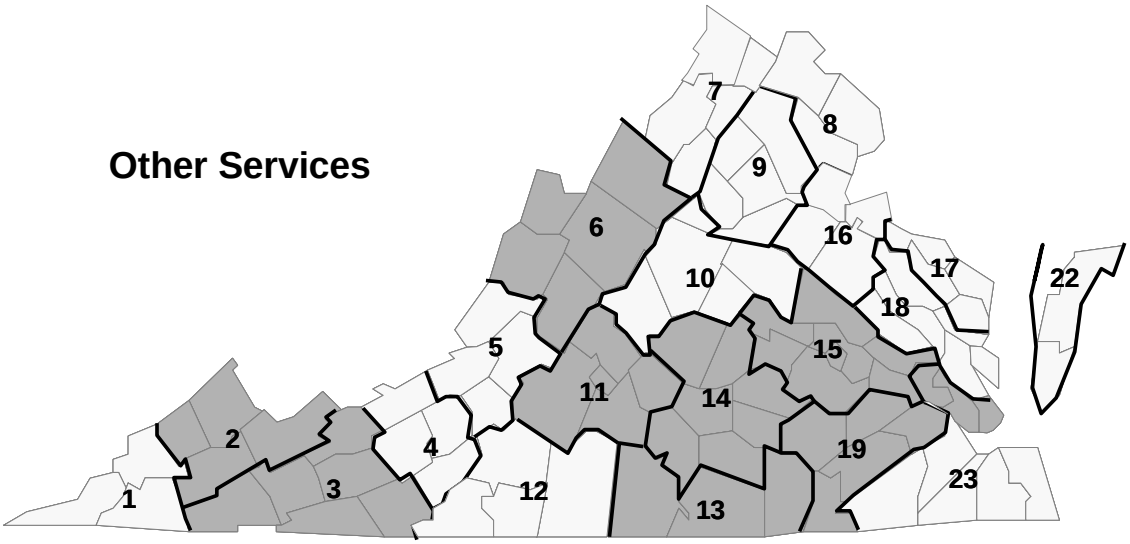
Of the $389.4 million spent on waiver services in FY 2004, according to detailed provider and recipient data provided by DMAS, 95.9 percent was spent on personal care (not including consumer-directed care), respite care, private duty and skilled nursing, day support, congregate residential, and in-home residential services. The remaining 4.1 percent, or $15.8 million, was spent on other services, such as adult companion care, adult day health care, assistive technology, environmental modifications, case management, crisis stabilization, family/caregiver training, nutritional supplements, personal emergency response system, supported employment, and therapeutic consultation. Rather than separately examining the distribution of each of these 11 services across the State, JLARC staff added together the payments for all of the remaining services that were made for Medicaid waiver recipients in each locality. The map in Figure 12 shows that there is no evidence of Medicaid recipients in the Southwestern or Southside regions having less access to these remaining services than recipients in other parts of the State. Likewise, Table 9 shows that there are no substantial differences in access between localities with high and low population densities.

Figure 12
Geographic Distribution of Services

Payments per capita for other Medicaid services

Above statewide average

At or below statewide average



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Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

Northern Virginia Has Proportionately Fewer Medicaid Waiver Recipients

The region of the State that did tend to have consistently lower proportions of its population receiving Medicaid waiver services was Northern Virginia. After controlling for the size of its poverty population, Northern Virginia was found to have below-average numbers of recipients of Medicaid personal care and respite care services. Likewise, after taking the size of its total population into account, Northern Virginia had below-average numbers of Medicaid recipients of day support and residential services, and received below-average payments per capita (total population) for other Medicaid waiver services.

Table 9

Distribution of Per-Capita Payments for Other Medicaid Services, by Locality

Per-Capita Payment[1] for Other Waiver Services	Population Density[2]	
	Low	High
High	35	23
Low	47	29

[1]A locality with a "high" per-capita payment means that the per-capita payment for other Medicaid waiver services is greater than the statewide average of $2.13 (where per capita is based on total population.)

[2]A "low" population density locality is defined as one having less than the statewide average of 188 people per square mile.

Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

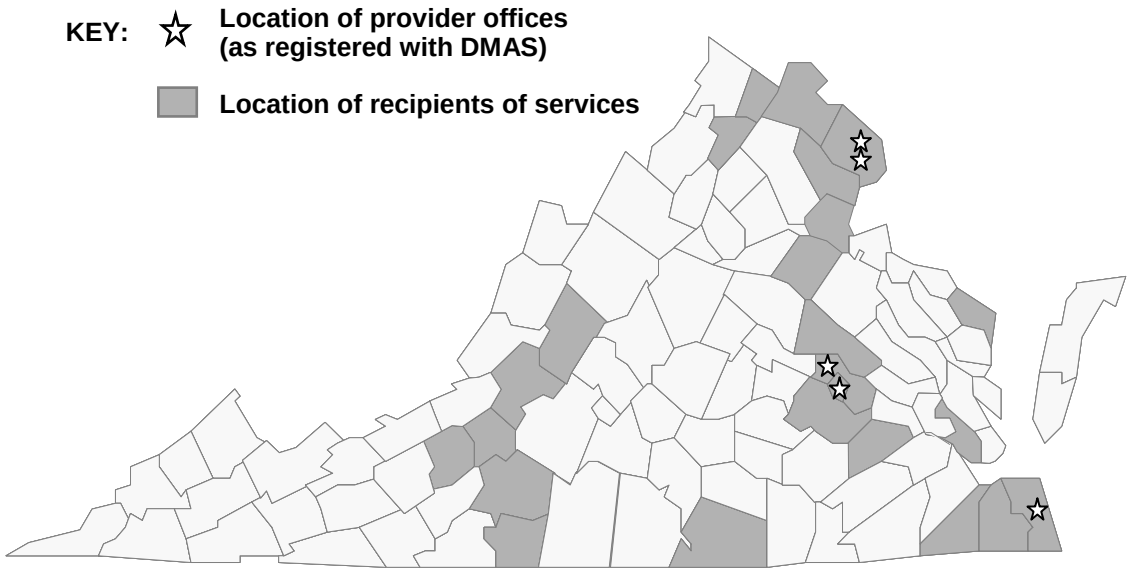
When JLARC staff asked providers in Northern Virginia why this appeared to be the case, the first response was always that Northern Virginia is more affluent than other regions of the State, so proportionately fewer people would be likely to apply for Medicaid services (especially because they would not likely be eligible). Another reason given was that Northern Virginia had more local government programs available that could be alternatives to participation in Medicaid, compared to other regions of the State. For example, one provider said that Northern Virginia has no individuals on waiting lists to receive day support services. Overall, providers indicated that access to home and community-based services in Northern Virginia is not a major problem at this time, although this situation could change if the number of providers declines.

Three Factors Help Explain the Geographic Distribution of Services

Three factors may help explain why the relationships expected by providers between access to services and location are not supported by the DMAS data. First, providers can serve broad geographic areas, including areas with lower population densities. Also, over the past four years more providers have entered the market than have left. Further, some providers appear to be more mission-driven than profit-driven and serve clients because they see a need.

Services Can Be Provided Over Broad Geographic Areas. Analysis of DMAS data indicates that many providers can deliver services well beyond their primary geographic areas of operation. For example, one provider of personal care, respite care, and private duty/skilled nursing services was registered with DMAS as having offices in the greater Richmond area, Northern Virginia, and Virginia Beach, but was providing services in Roanoke, Montgomery, Franklin and Henry counties (Figure 13). Some providers are large (such as national organizations with offices in

Figure 13
Range of Localities Served by a Single Provider



Source: JLARC staff analysis of FY 2004 Medicaid waiver recipient data from the Department of Medical Assistance Services.

most states), and they frequently open a branch office in a new locality. Other large providers (especially of personal care, respite care, and skilled nursing services) may be organized as franchises, so that services can be provided in new localities by selling the "new territory" to local operators, who would buy into the franchise and receive overhead services from the national office (such as legal assistance, sales and marketing services, information technology/computer support, and training).

In other cases, smaller agencies may be "spinoffs" from local non-profit or government agencies that already deal with the target populations. The fact that providers have shown considerable variety and creativity in how they organize their operations and deliver their services may help explain why the DMAS data did not show the expected major geographic gaps in the distribution of Medicaid waiver recipients.

More Providers Are Entering Than Leaving the Market. The market for Medicaid waiver services changes over the years, as do the participants in the market. A comparison of FY 2001, 2002, 2003 and 2004 DMAS data shows that a substantial number of providers left the market during the four-year period, but an even larger number of providers entered the market in those years.

Table 10 shows the number of providers of each type of service received by individuals on Medicaid HCB waivers. For each service, there are three mutually exclusive categories: (1) providers entering the market (providers first appearing in DMAS data in FY 2002, 2003, or 2004); (2) providers leaving the market (providers

Table 10

Providers of Medicaid Waiver Services in FYs 2001, 2002, 2003 and 2004

	Number of Providers		
Service	**Entering Market**	**Leaving Market**	**In Market All 4 Years**
Adult companion			8
Adult day health	22	9	33
AIDS case management	11		4
Assistive technology	16	14	22
Congregate residential	**59**	**21**	**118**
Crisis intervention			39
Crisis supervision			6
Day support	**16**	**9**	**112**
Environmental modification	6	1	
Family caregiver training	7	2	
In-home residential	**8**	**4**	**62**
MR case management	2		41
Personal Emergency Response System (PERS) and medication monitoring	1		
PERS installation	12		4
PERS monitoring	12		4
Personal care	**67**	**57**	**152**
Pre-vocational			2
Respite care	**61**	**33**	**128**
Private duty and skilled nursing	**17**	**14**	**35**
Supported employment (enclave)	2		25
Supported employment (individual)			7

Note: The numbers across different rows may be duplicative, because the same provider may be providing several services (such as personal care and respite care).

Source: JLARC staff analysis of DMAS Medicaid waiver provider data from FY 2001, 2002, 2003 and 2004.

of services in FY 2001 who were no longer providing them to Medicaid waiver recipients by FY 2004); and (3) providers who were serving Medicaid waiver recipients across all four years.

Even when examining each service separately, some general trends emerge. One is that, for most services, the largest number of providers have been in the market all four years. But for every service category, whether large or small, the number of providers entering the market exceeds the number leaving. This trend may also contribute to the apparent availability of HCB services throughout the State.

Some Providers Are More "Mission-Driven" than "Profit-Driven." A third factor that may contribute to the availability of Medicaid waiver services across all regions of the State is the stated motivation of many providers. When

asked why they provide services to Medicaid waiver recipients even though they report that they take a net loss per patient, some providers responded that their primary mission is to serve the patient's needs, not to make a financial profit. This response was especially frequent among non-profit or public agencies serving the MR and DD population, although it was also voiced among for-profit providers of personal care, respite care, and private duty and skilled nursing services.

If some providers are committed to providing their services for non-financial reasons, this may also contribute to the general availability of services throughout the State. It may be that up to now, "mission-driven" providers have been stepping in to meet the needs of Medicaid recipients, even in areas of the State where it may not be profitable to do so.

VIRGINIA'S MEDICAID PATIENT PAY PREVENTS SOME INDIVIDUALS FROM ACCESSING WAIVER SERVICES

Even though the data do not support the expected regional gaps in access to Medicaid home and community-based services, Virginia providers indicated that the patient pay required of some individuals can be a major barrier to these individuals receiving waiver services. Because individuals with a patient pay are only allowed to keep a relatively small personal maintenance allowance for all of their personal expenses, including rent, food, utilities, and other incidentals, some individuals decide that they cannot afford to receive HCB services through a Medicaid waiver. In recognition of the potential barriers of the patient pay, there have been recent attempts to reduce the patient pay by increasing the personal maintenance allowance for individuals receiving Medicaid waivers.

Background on the Medicaid Waiver Patient Pay and Personal Maintenance Allowance

The *Code of Federal Regulations (CFR)* requires certain individuals to contribute a patient pay towards their Medicaid HCB waiver services, depending on their earned and unearned income. Title 42 of the *CFR* also requires states to reduce their payments made for home and community-based service waivers by individuals' patient pay amounts. The patient pay is whatever amount of "countable" income remains after a personal maintenance allowance and all allowable deductions have been made for an individual. (Allowable deductions may include the maintenance needs of a spouse and/or dependent children living at home, and medical or remedial care expenses that are not reimbursed through Medicaid.) According to Title 42, the personal maintenance allowance must be "based on a reasonable assessment of need," but the amount of the personal maintenance allowance is set by each state.

For most HCB waivers in Virginia, the personal maintenance allowance for a single individual is 100 percent of federal Supplemental Security Income (SSI), which was $579 per month in 2005. This means that for single individuals who are required to contribute a patient pay, the remaining monthly income for all their living expenses, such as rent, food, clothing, and incidentals, is $579. Two exceptions

to this are that working individuals on the Elderly and Disabled with Consumer Direction (ED/CD), Mental Retardation (MR), Day Support, and Individual and Family Developmental Disabilities Support (DD) waivers may keep up to 300 percent of SSI if they are employed 20 or more hours per week, and the personal maintenance allowance for the AIDS waiver is 300 percent of SSI. However, individuals receiving the Technology Assisted Waiver and those individuals with only unearned income on the ED/CD, MR, Day Support, and DD Waivers are only permitted a personal maintenance allowance of 100 percent of SSI.

Virginia's Personal Maintenance Allowance Is Relatively Low and There Have Been Recent Attempts to Increase the Allowance

Virginia's average personal maintenance allowance for its waiver programs has historically been lower than many other states. A study in 2000 by the Congressional Research Service found Virginia to be in the bottom ten states in terms of allowing only 100 percent of SSI for the personal maintenance allowance for HCB waiver participants.

During the course of this JLARC study, providers frequently mentioned that Virginia's patient pay prevents some eligible individuals from accessing waiver services. Although conclusive data is not available to indicate the extent to which this happens, it is a significant issue for those individuals who are unable to access waiver services. Case Example 9 describes a situation in which a Medicaid waiver-eligible individual is unable to access services because her monthly expenses exceed Virginia's personal maintenance allowance.

Case Example 9

Ms. Anderson qualifies for the Medicaid Elderly and Disabled with Consumer Direction (ED/CD) Waiver. She is 63 years old and requires total care due to Guillian-Barre disease and brain damage. She is non-ambulatory, bedbound, and transferred by lift. She has a catheter and is incontinent of bowel. She is tube fed, and requires total care for bathing and dressing. A relative is staying with Ms. Anderson as a caregiver but needs assistance in providing her care.

Ms. Anderson has a monthly income of approximately $1,200 from a combination of Social Security and disability income from her prior job. Based on her monthly income, Ms. Anderson's monthly patient pay would be $621 ($1,200 minus $579).

Ms. Anderson's monthly expenses are: *$440 Rent*
$75 Utilities
$45 Phone

These expenses alone total $560 a month. The personal maintenance allowance would leave her only $19 for food, clothing, and other expenses.

Source: Based on a case study provided by the City of Richmond Department of Social Services.

According to providers, if an individual's patient pay is too high it can be problematic for the individual, the provider, and, ultimately, the State. In some cases, an eligible individual that cannot afford the patient pay will go without needed services. In other cases, an individual will begin receiving services but will not pay the full patient pay. This is problematic for providers because DMAS only reimburses them for the net Medicaid reimbursement amount, leaving it up to the provider to collect clients' patient pay. If an individual is unable to access HCB services, this may also be less cost effective for the State. Some of these individuals may ultimately be admitted to an institution at some point, such as a nursing home or hospital, which is more costly for the State.

Recognizing the barrier to HCB services that Virginia's patient pay creates for some individuals, there have been recent recommendations and attempts to increase the personal maintenance allowance for Medicaid waiver recipients. Both the Joint Commission on Health Care (JCHC) and Virginia's Olmstead Task Force have recommended that the personal maintenance allowance be increased to up to 300 percent of SSI. According to DMAS and the Virginia Poverty Law Center, setting the personal maintenance allowance at 300 percent of SSI would effectively eliminate the patient pay for most individuals, because 300 percent of SSI is the financial eligibility criterion to qualify for the waivers. Most recently, budget amendments were submitted in both the House of Delegates and the Senate during the 2005 Session to increase the personal maintenance allowance for all Medicaid HCBS waivers to 300 percent of the federal SSI. The costs of the House and Senate budget amendments were estimated to be $4.3 million in State general funds and $4.2 million in federal non-general funds annually. Neither of these amendments was adopted by the 2005 General Assembly.

III. Assessment of Medicaid Reimbursement Rates for Home and Community-Based Services and Other Issues

Many providers in Virginia have indicated that the State's current rates for home and community-based services are too low. JLARC staff focused on the rates for the six services that accounted for approximately 98 percent of Medicaid waiver expenditures in FY 2004, according to the *FY 2004 Statistical Record of the Virginia Medicaid Program*. These services include personal care, respite care (for personal care services), private duty and skilled nursing services, in-home residential services, congregate residential support, and day support services. Based on an analysis of the rates for these services, some evidence supports providers' claims that rates may be too low for some services. As a result, despite data suggesting that the current reimbursement rates do not appear to have caused the expected regional problems with access to services at this time, the concerns raised by providers and the evidence supporting their concerns may warrant further consideration of whether rates for services provided on an individual basis should be increased. For services provided in a group setting, the results of whether the rates appear to be too low or too high are mixed, depending on the situation in which services are provided.

In addition, there are several issues regarding services that are provided under the Mental Retardation (MR) Waiver and Individual and Family Developmental Disabilities Support (DD) Waiver in particular. One issue is providing a Northern Virginia rate differential for waiver services that are provided under the MR and DD waivers, which would be consistent with how nearly all other waiver services are reimbursed. The other issues are the need for alternative rate structures for waiver services provided in group settings and whether general supervision costs could be reimbursed as part of congregate residential support services.

EVIDENCE SUPPORTS PROVIDERS' CLAIMS THAT RATES ARE TOO LOW

Several factors appear to support the claim that current reimbursement rates for HCB services are too low. One is that Medicaid reimbursement rates for HCB services generally have not risen with inflation. Another is that Virginia's rates for several services are also low compared to other states. Further, it appears that current reimbursement rates are somewhat arbitrary and may prevent some HCB providers from offering a competitive wage or living wage to direct care staff.

Home and Community-Based Service Providers Indicate That Rates Are Too Low

Throughout the course of this study, providers across nearly all of the home and community-based services reviewed by JLARC staff said that current Medicaid reimbursement rates are too low and do not fully cover their costs. Providers further

suggested that this could affect their willingness and ability to serve Medicaid recipients in the long run, which could in turn affect future access to HCB services among Medicaid recipients.

Providers said that they have dealt with the currently inadequate Medicaid rates but that they may not be able to continue to do so. For example, providers reported that they have been forced to contain costs by cutting or eliminating benefits for full-time personnel, not increasing salaries for direct care workers for multiple consecutive years, or not reimbursing direct care staff for transportation costs. Some providers also mentioned that they have subsidized the Medicaid rates with other sources of revenue, such as fund raising or local government revenue.

While these measures have worked in the short term, providers stated that they are not long-term solutions. For example, not providing benefits or salary increases impacts providers' ability to compete in the labor pool for direct care staff. As a result, even though evidence in Chapter II suggests that services are generally available across the State, there may be situations in which providers are temporarily unable to serve clients (as shown in Case Example 10). In addition, other sources of revenue, such as fund raising and local government funds, may not be reliable for the long term.

Case Example 10

One Medicaid Elderly and Disabled / Consumer Directed waiver recipient has been wheelchair-bound for over 20 years, because of a spinal cord injury. She says that high turnover and unreliability of personal care aides create problems. For example, an aide did not show up at the appointed time, and she could not get in or out of bed for hours until she could locate a substitute. In the meantime, it was urgent for her to be moved to relieve the pressure of her body weight on key spots. She says that having Consumer Directed (CD) services has made a big difference in her quality of life, because through CD services she was able to find an aide who could care for her in the evening. However, CD services did not solve everything. Her evening aide recently told her that she will be moving out of the area, and she anticipates it will be difficult to find a replacement because of the limited pool of caregivers in the area.

Source: Case example provided by a Virginia Medicaid Waiver recipient

According to providers, the long-term consequences of inadequate rates may be that providers will: (1) stop providing Medicaid HCB waiver services and move to other lines of service, or (2) be more selective in choosing clients to serve. For example, providers indicated that some Mental Retardation (MR) Waiver providers have closed group homes that serve Medicaid waiver recipients and converted them to small intermediate-care facilities for the mentally retarded (ICF/MRs), which are reimbursed at a higher rate. One provider stated that a significant reason for the change was that the Medicaid reimbursement rate for ICF/MRs is far greater than the Medicaid rate for residential or day support waiver services.

Providers also reported that they may become more selective about whom they serve if rates continue to be problematic. Providers of personal care services suggested that in the future they may have to take a higher proportion of private pay clients, who pay higher rates than Medicaid recipients. Additionally, a day support provider indicated that if rates remain at their current level, there will be more "cherry picking," meaning that providers will select clients who require less staff time rather than clients with greater needs.

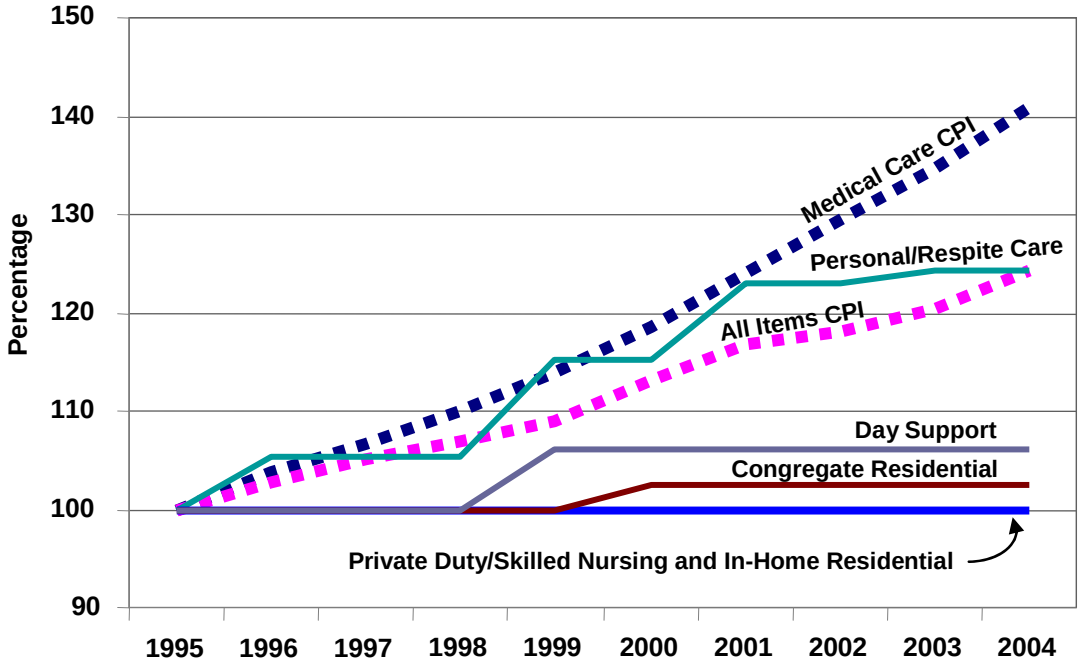
Medicaid Reimbursement Rates Generally Have Not Risen with Inflation

In the ten years between 1995 and 2004, reimbursement rates for many Medicaid home and community-based services have remained relatively flat compared to inflation measures over the same time period. Reimbursement rates for Medicaid HCB waiver services are adjusted only upon action of the Virginia General Assembly. In contrast, other similar Medicaid services (such as nursing home care and home health services) receive routine inflation adjustments as a part of the biennial budget process.

Figure 14 illustrates the disparity between rates paid for waiver services and the rate of inflation between 1995 and 2004. Four of the six services received increases ranging from zero to six percent. Comparatively, the Consumer Price Index of all items (CPI), which is the United States' most accepted measure of overall inflation, rose 22 percent. The Medical Care CPI rose 35 percent over this time period. Only the rate increases for personal care and respite services, which are reimbursed at the same rate, approximated the overall increase in the CPI over the ten year period. However, given that health care industry costs generally rise faster than the overall costs of general goods and services, keeping pace with the CPI may not be enough of an inflation adjustment to keep up with costs for more medically oriented HCB services, such as personal care and private duty and skilled nursing.

Figure 14

Changes in Medicaid Waiver Rates Compared to Inflation, 1995 - 2004



Note: Graph lines were produced by applying inflation rates and any annual waiver rate increases since 1995 to a baseline value of 100.

Source: JLARC staff analysis of data from the Department of Medical Assistance Services and the U.S. Bureau of Labor Statistics.

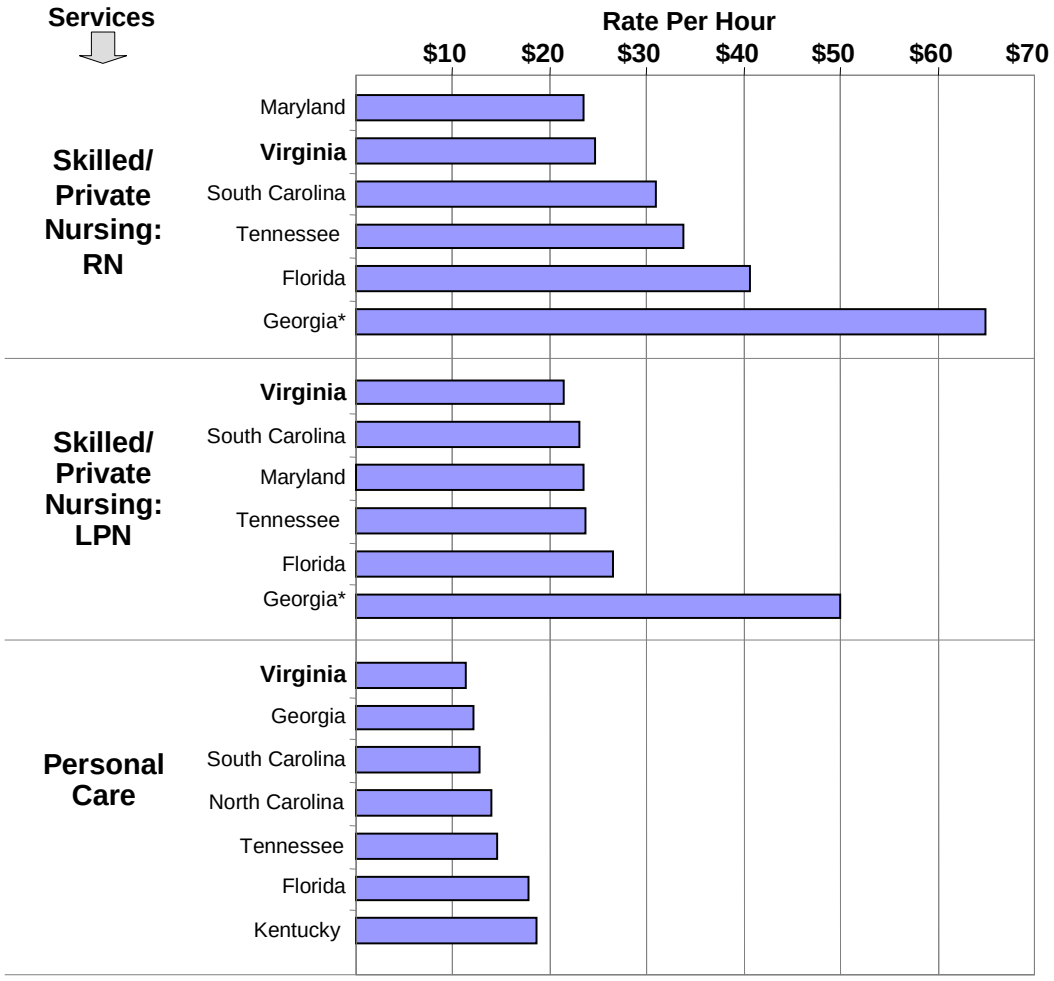
Virginia's Medicaid Rates Are Low Compared to Other States

Overall, Virginia's reimbursement rates for some HCB services are low compared with other states (Figure 15). JLARC staff reviewed the rates for seven states from the Southeast and mid-Atlantic regions. (An additional four states in these regions were contacted but did not provide information on their rates.)

Only selected rates could be compared because of differences in how reimbursement is managed. However, among the six states that offer private duty and skilled nursing RN and LPN services and the seven that offer personal care, Virginia ranks towards the bottom. Virginia's rates are substantially below those of most other states for private duty and skilled nursing RN services. Only Maryland's rates for RN services are lower than Virginia's, but Maryland is also the only state in Figure 15 that reimburses RN and LPN services at the same rate. The disparity is less between Virginia and other states for skilled LPN services (with the exception of Georgia) and personal care services, although Virginia still ranks last for these services.

Figure 15

Virginia's Reimbursement Rates Compared to Other States



* Reimbursement is provided on a per-visit basis. A typical visit could range from less than an hour to several hours.
Source: JLARC staff contacts with other mid-Atlantic and Southeastern states.

Reimbursement Rates for Services Provided on an Individual Basis Do Not Allow for a Competitive Wage or a Living Wage for Direct Care Staff

As mentioned previously, providers of HCB services indicated that current Medicaid reimbursement rates are often inadequate to cover their costs. In particular, providers said that they are unable to provide adequate direct care wages or benefits to employees and cover overhead costs with existing reimbursement rates.

When assessing provider costs, the most significant factor influencing costs is the wage rate providers pay to direct care staff. Therefore, JLARC staff used two approaches to determine whether current reimbursement rates cover potential provider costs. These two approaches are the comparable position approach and the living wage approach. Compared to either of these approaches, reimbursement

rates appear to be low for most services provided on a one-on-one basis. JLARC staff were unable to make meaningful comparisons of reimbursement rates using these approaches for services provided in a group setting, in particular congregate residential support and day support. These rates will be discussed later in this chapter.

The Comparable Position Approach and Living Wage Approach for Estimating Provider Costs. The comparable position approach and the living wage approach are two alternative methods for estimating potential costs of home and community-based service providers. The wage rate for direct care staff is the primary cost component for both the comparable position and the living wage approaches. However, in addition to direct care wages, providers also incur additional legitimate business costs, including fringe benefits for direct care staff, and supervisory, administrative, and overhead costs. Therefore, each approach includes three main cost component categories: hourly wages of direct care staff; fringe benefits for direct care staff; and supervisory, administrative and overhead costs. Both approaches also make a distinction between wages paid in Northern Virginia and the rest of the State. A more detailed discussion of how the cost components are estimated under each approach is in Appendix D.

Comparable Position Approach. Providers indicated that they compete in the same labor pool as State institutions, hospitals, and nursing homes. Therefore, hourly wages for this approach are based on what the State or nursing homes pay staff in comparable positions. For most services, direct care staff are assumed to be paid comparable hourly wages as State employees providing comparable services. Fringe benefits are also based on the State's fringe benefit package. Staff directly providing personal or respite care services are assumed to receive fringe benefits and be compensated at a level comparable to nurse aides in nursing homes. In addition, JLARC staff assumed rates for supervisory, administration, and overhead costs that are consistent with current practice among providers. The comparable position approach represents a more competitive level of compensation, so the resulting estimated costs could be considered to be at the higher end of a range of possible cost estimates.

Living Wage Approach. An alternative and less costly approach would be based on a living wage. This approach assumes that direct care workers would be paid only a "living wage," not a competitive market wage. (This assumption is not realistic in some cases, such as for nurses.) Although there are different ways of defining a living wage, for the purposes of this report, a living wage is defined as a pay rate that allows individuals to be compensated at a level high enough that they do not qualify for government assistance. *The Self-Sufficiency Standard for Virginia* measures how much income is needed for a family to meet its basic needs in each Virginia locality, based on family size and composition, and is described further in Appendix D. The Virginia Department of Social Services plans to use *The Self-Sufficiency Standard* as a benchmark to assess the degree to which their customers achieve financial independence. Based on this standard, JLARC staff calculated an average living wage for Northern Virginia and the rest of the State. The living wage approach assumes that a minimum level of fringe benefits is provided for direct care staff, in a manner consistent with current practice among HCB service providers. As with the comparable position approach, this approach assumes amounts for su-

pervisory, administrative, and overhead costs that are consistent with current practice.

Comparing Reimbursement Rates with the Comparable Position and the Living Wage Approaches for Estimating Key Provider Costs. Table 11 shows that current Medicaid reimbursement rates are generally below estimated HCB service provider costs using either the living wage approach or the comparable position approach. As a result, it appears that most current Medicaid reimbursement rates generally would not allow providers to pay direct care workers a living wage, provide them with current levels of fringe benefits, and cover overhead costs at their current level. The disparity is more pronounced when current rates are compared to estimated provider costs using the comparable position approach. Current Medicaid rates are well below provider costs estimated under this approach, which would seem to indicate that home and community-based providers are not able to compete with State institutions, hospitals, or nursing homes for qualified direct care staff. If Medicaid rates do not allow for the payment of a competitive wage, Medicaid waiver recipients may also have difficulty finding direct care staff, as illustrated in Case Example 11, even though Chapter II indicates that expected geographic differences in access due to current reimbursement rates do not appear to exist.

Case Example 11

One couple's daughter has 14 different diagnosed disabilities including severe mental retardation, cerebral palsy, seizures, and autistic tendencies. The MR waiver provided their daughter with day support, which has been an opportunity for her to have social interaction and develop new skills. However, other waiver services, such as consumer direct personal care, have not been accessible. They ask, "What incentive does a person…no matter how dedicated [have]…to continue in this field?" They feel that finding a caregiver to work evenings and weekends for a person with multiple, intense needs, is difficult. And, it is nearly impossible when they can only pay $7.80 per hour [the Medicaid rate for consumer-directed personal care] and the caregiver must pay for gas and taxes. The consequence has been that they are unable to maintain a stable staff willing and trained to meet their daughter's needs.

Source: Parents of an MR Waiver participant.

Several clarifications should be made regarding Table 11. First, because consumer-directed personal and respite care aides are not employed by an agency, no costs are included for supervision, administration, and overhead costs. Second, given the current competitive labor market for nurses, it is not realistic to assume that nurses could be paid at the "living wage" level. Comparing Medicaid rates with the comparable position approach is more appropriate, and therefore, a cost estimate for nurses is not provided using the living wage approach. Finally, two estimates of provider costs are included for in-home residential services due to differing assumptions for supervision, administration, and overhead costs. These estimates are further explained in Appendix D.

Table 11

Comparison of Medicaid Rates with Estimated Costs Using The Living Wage Approach and the Comparable Position Approach:

Personal Care, Respite Care, Private Duty Nursing, and In-Home Residential Services

		Living Wage Approach				Comparable Position Approach			
Service	**FY 2006 Medicaid Rate**	**Direct Care Workers' Hourly Wage**	**Direct Care Workers' Fringes**	**Super-vision, Admin. & Overhead**	**Sum of Cost Components**	**Direct Care Workers' Hourly Wage**	**Direct Care Workers' Fringes**	**Super-vision, Admin. & Overhead**	**Sum of Cost Components**
Personal Care	$11.93	$8.71	$1.39	$5.05	$15.16	$11.10	$3.11	$6.44	$20.65
Personal Care (NoVa)	14.05	12.61	2.02	7.31	21.94	13.10	3.67	7.60	24.37
Respite Care	11.93	8.71	1.39	5.05	15.16	11.10	3.11	6.44	20.65
Respite Care (NoVa)	14.05	12.61	2.02	7.31	21.94	13.10	3.67	7.60	24.37
Consumer Directed Personal Care	8.19	8.71	1.39	n/a	10.10	11.10	3.11	n/a	14.21
Consumer Directed Personal Care (NoVa)	10.61	12.61	2.02	n/a	14.63	13.10	3.67	n/a	16.77
Consumer Directed Respite Care	8.19	8.71	1.39	n/a	10.10	11.10	3.11	n/a	14.21
Consumer Directed Respite Care (NoVa)	10.61	12.61	2.02	n/a	14.63	13.10	3.67	n/a	16.77
Private Duty Nursing – RN	24.70	n/a	n/a	n/a	n/a	21.69	10.72	12.58	44.99
Private Duty Nursing -- RN (NoVa)	30.00	n/a	n/a	n/a	n/a	24.79	11.73	14.38	50.90
Private Duty Nursing – LPN	21.45	n/a	n/a	n/a	n/a	14.57	8.39	8.45	31.41
Private Duty Nursing -- LPN (NoVa)	26.00	n/a	n/a	n/a	n/a	16.65	9.07	9.66	35.38
In-Home Residential	18.90	8.71	2.96	3.79	15.46	10.55	7.08	4.59	22.22
In-Home Residential (NoVa)	18.90	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
In-Home Residential -- Alternative overhead	18.90	8.71	2.96	7.84	19.51	10.55	7.08	9.50	27.13
In-Home Residential (NoVa) -- Alt. overhead	18.90	12.61	4.29	11.35	28.25	12.05	7.57	10.85	30.47

Note: Nursing rates shown are for Private Duty Nursing Services provided under the Technology Assisted Waiver, which accounts for approximately 90 percent of total nursing hours provided under all Medicaid home and community-based waivers.

Source: JLARC staff analysis

OPTIONS FOR INCREASING MEDICAID RATES FOR HOME AND COMMUNITY-BASED SERVICES

Although Chapter II indicates that the expected regional differences in access to Medicaid home and community-based services do not appear and that providers are continuing to enter this market, analysis presented in this chapter suggests that, nevertheless, there may be problems with the current rates for these services. Potential problems with the rates could be compounded in the future as the demand for services increases. Therefore, the concerns raised by providers and evidence supporting these concerns may warrant further consideration of whether rates for some services should be increased. Two ways that rates could be increased include:

- Providing an annual inflation adjustment; and
- Rebasing rates for HCB services provided on an individual basis using assumed targets for direct care staff compensation.

Table 12 illustrates the cost of adjusting each of the rates reviewed in this study per dollar increase based on FY 2004 units of service. While the cost estimates and illustrative examples included in this report focus on the six largest services, similar adjustments could be made for other services provided through the HCB waivers.

Table 12

Cost of Adjusting HCB Rates Per Dollar Increase

(Based on FY 2004 Units of Service Provided)

Service	Units of Service Provided (FY 2004)	Estimated Cost per Dollar Increase in Reimbursement Rate (in Millions)
Personal/Respite Care	9,623,524	$9.62
Personal/Respite Care (NoVa)	1,281,552	1.28
Personal/Respite Care –CD	1,594,406	1.59
Personal/Respite Care –CD (NoVa)	509,818	0.51
Private duty and skilled nursing – RN	146,838	0.15
Private duty and skilled nursing – RN (NoVa)	48,926	0.05
Private duty and skilled nursing – LPN	524,237	0.52
Private duty and skilled nursing – LPN (NoVa)	204,558	0.20
In-Home Residential	1,260,277	1.26
Congregate Residential	12,782,024	12.78
Day Support—Regular	391,489	0.39
Day Support – High Intensity	1,215,843	1.22

Source: JLARC staff analysis of data provided by the Department of Medical Assistance Services.

When deciding whether to revise reimbursement rates for HCB services, two points should be considered. One is that the State is able to limit its financial exposure to Medicaid waivers through the number of slots for each waiver. Consequently, even if the cost of a given waiver changes due to rate changes, the number of Medicaid recipients that could be affected would be limited unless a separate policy decision were made to increase the number of slots for a given waiver as well.

Another consideration is that even without Medicaid home and community-based services, some individuals may enter the Medicaid long-term care system or other State institutional systems at some point. These institutional settings include State plan Medicaid long-term care institutions (such as nursing homes and ICF/MR facilities), hospitals, or possibly jail or prison for individuals with intense behavioral problems related to MR or DD disabilities. Once an individual is placed in an institutional setting, the State would have to pay for this more expensive option.

Provide an Annual Inflation Adjustment for Medicaid HCB Service Rates

One option for adjusting Medicaid HCB service rates is to provide a routine inflation adjustment. As shown previously in this chapter, because the General Assembly does not regularly adjust rates, most rates have not kept up with inflation. Further, providers overwhelmingly commented that rebasing rates without adding an annual inflation factor would only temporarily mitigate any problems with rates. In fact, one provider commented that the question should be asked as to why costs are *not* expected to increase each year. Even though the General Assembly has not routinely adjusted HCB rates for inflation, it does have a history of making annual inflation adjustments for comparable Medicaid services, such as nursing homes and home health services, and could do so for HCB services.

As previously indicated, the Consumer Price Index for all goods and services (CPI) could be used as a basis for adjusting HCB service rates. Table 13 shows how FY 2004 rates compare to FY 2005 and FY 2006 rates if these had been adjusted by the CPI annually, and how these rates compare to the current FY 2006 rates. The General Assembly did increase rates for many of the services listed in Table 13 in FY 2006 by an amount that approximated the CPI for the past two years. However, the General Assembly has not consistently made such an adjustment for services, other than personal care, and no adjustment was included for private duty nursing in FY 2006.

Based on FY 2004 service levels and the cost per dollar increase in reimbursement rate included in Table 12, the total cost of increasing the FY 2004 rates to the FY 2006 CPI rate is estimated to be approximately $20.5 million (the cost to the State would be about $10.2 million in general funds). This total cost is approximately $1.4 million more than the estimated cost to increase rates to the FY 2006 level approved by the General Assembly, assuming constant FY 2004 levels of service, and is largely due to providing an inflation adjustment to the rates for private duty nursing services.

Table 13

Increases in HCB Rates Based on the CPI

Service	FY 04 Reimb. Rate	FY 05 Rate with CPI (2.53%)	FY 06 Rate with CPI (2.50%)	FY 06 Reimb. Rate
Personal/Respite Care	$11.36	$11.65	$11.94	$11.93
Personal/Respite Care (NoVa)	13.38	13.72	14.06	14.05
Personal/Respite Care –CD	7.80	8.00	8.20	8.19
Personal/Respite Care – CD(NoVa)	10.10	10.36	10.61	10.61
Private duty and skilled nursing – RN	24.70	25.32	25.96	24.70
Private duty and skilled nursing – RN (NoVa)	30.00	30.76	31.53	30.00
Private duty and skilled nursing – LPN	21.45	21.99	22.54	21.45
Private duty and skilled nursing – LPN (NoVa)	26.00	26.66	27.32	26.00
In-Home Residential	18.00	18.46	18.92	18.90
Congregate Residential	12.81	13.13	13.46	13.45
Day Support—Regular	23.99	24.60	25.21	25.19
Day Support – High Intensity	34.15	35.01	35.89	35.86

Note: Nursing rates shown are for private duty nursing services provided under the Technology Assisted Waiver, which account for approximately 90 percent of total nursing hours provided under all Medicaid HCB waivers.

Source: JLARC staff analysis.

It has also been discussed that the general CPI for all goods and services does not sufficiently reflect inflation levels experienced by the medical sectors of the economy. For these sectors, the Medical Care CPI is a better approximation of the rates of inflation. Private duty and skilled nursing providers indicated that they compete with hospitals and other medical entities when recruiting direct care staff. Additionally, although personal care and respite care providers stated that they compete with entry-level employers such as fast food and retail, they indicated that they also compete with nursing homes and hospitals. Because private duty and skilled nursing providers, personal care providers, and respite care providers all compete in labor pools that include segments of the medical industry, a case can be made that they should receive inflation increases that are more closely aligned with the levels of inflation experienced in the medical community.

Table 14 shows how the FY 2004 rates for personal care, respite care, and private duty and skilled nursing compare to FY 2005 and FY 2006 rates if they had been adjusted by the Medical Care CPI annually, and how these rates compare to the current FY 2006 rates. When the Medical Care CPI is used to adjust rates for inflation, all rates are above the current FY 2006 rates. Based on the cost estimates in Table 12, the total cost of increasing the FY 2004 rates to the FY 2006 Medical

Table 14

Increases in HCB Rates Based on the Medical Care CPI

Service	FY 04 Reimb. Rate	FY 05 Rate with Medical Care CPI (4.16%)	FY 06 Rate with Medical Care CPI (4.28%)	FY 06 Reimb. Rate
Personal/Respite Care	$11.36	$11.83	$12.34	$11.93
Personal/Respite Care (NoVa)	13.38	13.94	14.53	14.05
Personal/Respite Care –CD	7.80	8.12	8.47	8.19
Personal/Respite Care – CD(NoVa)	10.10	10.52	10.97	10.61
Private duty and skilled nursing – RN	24.70	25.73	26.83	24.70
Private duty and skilled nursing – RN (NoVa)	30.00	31.25	32.59	30.00
Private duty and skilled nursing – LPN	21.45	22.34	23.30	21.45
Private duty and skilled nursing – LPN (NoVa)	26.00	27.08	28.24	26.00

Note: Nursing rates shown are for private duty nursing services provided under the Technology Assisted Waiver, which account for approximately 90 percent of total nursing hours provided under all Medicaid HCB waivers.

Source: JLARC staff analysis.

Care CPI rates is estimated to be approximately $14.3 million ($7.2 million in State general funds). This is approximately $5.8 million more in total funds than it would cost to increase those rates by the CPI for all goods and services and approximately $7.1 million more than the total estimated cost to increase rates to the FY 2006 level approved by the General Assembly, assuming constant FY 2004 levels of service.

Rebase Rates for HCB Services Provided on an Individual Basis

This chapter previously compared current Medicaid reimbursement rates for HCB services provided on an individual basis (personal care, respite care, private duty and skilled nursing, and in-home residential services) to two alternative approaches for estimating provider costs – the living wage approach and the comparable position approach. Rates for HCB services could be rebased using one of these two approaches.

Table 15 shows possible reimbursement rates based on the living wage and comparable position approaches. A lower cost alternative would be to rebase rates using the living wage approach, and a higher cost alternative would rebase rates using the comparable position approach. For situations where the living wage alternative is lower than the current reimbursement rate, a living wage option is not included in Table 15.

Table 15

Alternatives for Rebasing Medicaid HCB Rates Based on Assumptions for Direct Care Staff Wages

Service	FY 2006 Reimbursement Rate	Rate Based on Living Wage Approach	Rate Based on Comparable Position Approach
Personal/Respite Care	$11.93	$15.16	$20.65
Personal/Respite Care (NoVa)	14.05	21.94	24.37
Personal/Respite Care –CD	8.19	10.10	14.21
Personal/Respite Care –CD (NoVa)	10.61	14.63	16.77
Private duty nursing –RN	24.70	N/A	44.99
Private duty nursing –RN (NoVa)	30.00	N/A	50.90
Private duty nursing – LPN	21.45	N/A	31.41
Private duty nursing – LPN (NoVa)	26.00	N/A	35.38
In-Home Residential	18.90	N/A	22.22
In-Home Residential (NoVa)	18.90	22.38	24.86
In-Home Residential – Alternative Overhead	18.90	19.51	27.13
In-Home Residential – Alternative Overhead(NoVa)	18.90	28.25	30.47

Note: Nursing rates shown are for private duty nursing services provided under the Technology Assisted Waiver, which account for approximately 90 percent of total nursing hours provided under all Medicaid HCB waivers.

Source: JLARC staff analysis.

The total cost for rebasing the rates in Table 15 using the living wage alternative is considerable. It is estimated to range from approximately $46.7 million to $48.2 million ($23.3 million to $24.1 million in State general funds), assuming FY 2004 utilization levels and depending on the overhead assumption for in-home residential support.

The total cost of rebasing rates under the comparable position alternative is substantially higher. It is estimated to range from approximately $125.5 million to $131.8 million ($62.8 million to $65.9 million in State general funds), depending on the overhead assumption for in-home residential services.

Although these options appear relatively costly, it is important to keep in mind that individuals who are eligible for these services may require services from the State's long-term care institutions if they do not receive HCB services. As mentioned in Chapter I, the current cost of institutional care is typically two to three times the cost of serving these individuals in an HCB setting.

If a decision is made to rebase Medicaid rates, a further issue is whether to mandate that any rate increase be passed on to direct care staff. Although nearly all

HCB providers indicated that a significant problem with current reimbursement rates is that they are unable to pay direct care staff a competitive wage, some Virginia providers have not consistently passed on rate increases to direct care staff.

Several states have tried to ensure rate increases are passed on to direct care workers by implementing wage pass-through programs. In fact, in FY 2000 the Virginia General Assembly implemented such a program for certified nurse aides (CNA) in nursing homes. However, evidence of the effectiveness of wage pass-through programs on the recruitment and retention of direct-care workers is limited. DMAS staff indicated that it was very burdensome to ensure that the 2000 rate increase for nursing homes was used to provide higher CNA salaries, and that it would probably be even more difficult with HCB providers. However, enforcement of a wage pass-through to direct care workers could be facilitated by conducting random audits of HCB providers, as opposed to the universal audits that were conducted of nursing homes.

ISSUES WITH THE RATE STRUCTURE FOR MR AND DD WAIVER SERVICES

A number of issues with services provided under the Mental Retardation (MR) Waiver and the Individual and Family Developmental Disabilities Support (DD) Waiver were identified during this study and should be addressed. First, several services provided exclusively under the MR and DD waivers do not receive a Northern Virginia rate differential, which differs from how nearly all other waiver services are reimbursed. In addition, other issues may warrant additional review, including determining whether Virginia should adopt an alternative rate structure for services provided in group settings and whether general supervision costs could be reimbursed as part of congregate residential support services.

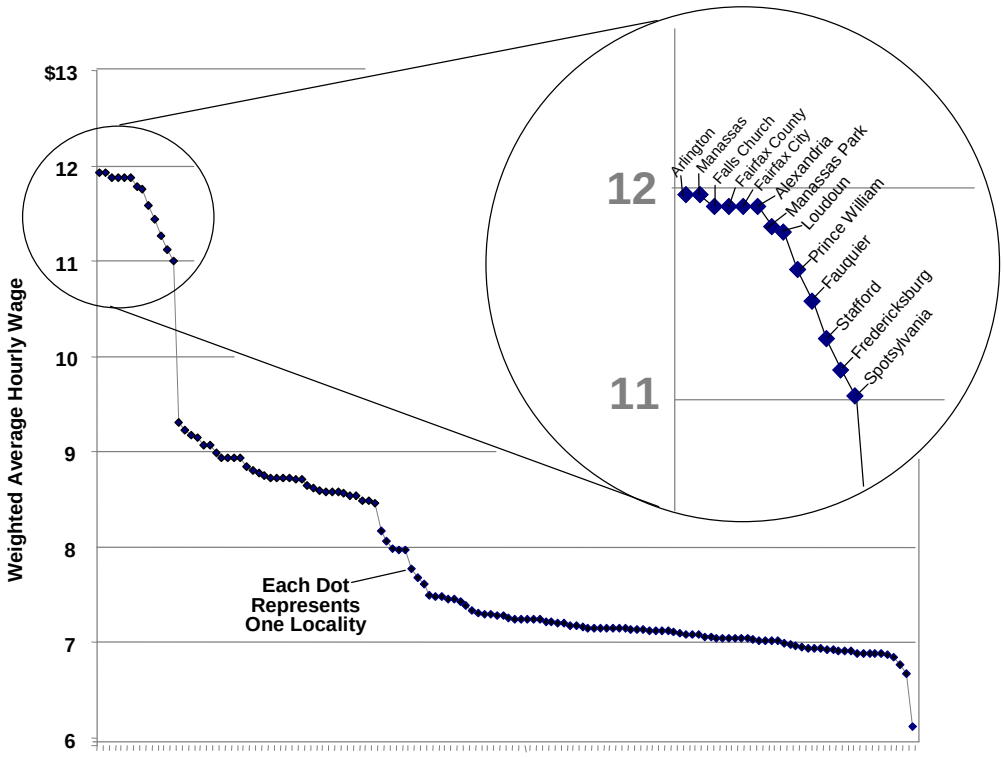
Apply a Northern Virginia Rate Adjustment for MR and DD Services

Most HCB services receive a rate differential for Northern Virginia reflecting the higher cost of living in this region of the State. For example, agency provided personal and respite care, the most widely used services, receive a 17.5-percent rate differential for Northern Virginia. However, several services provided exclusively through the Mental Retardation (MR) and Developmental Disabilities (DD) waivers do not receive any regional differential. These services include congregate residential, in-home residential, day support, and several other services that are provided exclusively under the MR and DD waivers. There is no evidence that indicates why these services would be less likely than others to cost more in Northern Virginia. Therefore, it seems appropriate for the State to provide a differential for these services as well.

There is adequate evidence that provider costs, particularly wage costs, are higher in Northern Virginia. As shown in Figure 16, average living wage rates calculated for different localities of the State are markedly higher in Northern Virginia. (Appendix D explains how these average living wage rates were derived.) Recogniz-

Figure 16

Living Wage in Virginia Localities



Source: JLARC staff analysis of data from *The Self-Sufficiency Standard for Virginia.*

ing this higher cost of living, the State's own salary scale provides a differential for Northern Virginia State employees.

Because higher wages would affect all HCB services, it would be appropriate to provide a Northern Virginia differential for all the services under the MR and DD waivers that are not receiving such an adjustment. The total cost of providing a 17.5-percent differential for congregate residential, in-home residential and day support reimbursement rates is estimated to be approximately $9.2 million annuall (approximately $4.6 million in State general funds), based on FY 2005 waiver payments made to Northern Virginia providers. If all other services provided exclusively through the MR and DD waivers were to receive such an adjustment, the total cost is estimated to be an additional $400,000 ($200,000 in State general funds) annually.

Revise the Rate Structure for HCB Services Provided in Group Settings

JLARC staff attempted to compare Medicaid rates for HCB services provided in a group setting (in particular, congregate residential and day support services) by using the comparable position approach and the living wage approach demonstrated earlier. However, it was not possible to draw a conclusion as to the

adequacy of these rates because of their current structure, which is largely based on a constant, per-client amount and does not align reimbursement amounts with the costs that providers face in different situations. Virginia appears somewhat unusual in reimbursing providers using a constant per-client amount for services provided in a group setting. As a result, there appears to be a need for a working group to review whether a different rate structure for these services may be more appropriate.

Problems with the Current Rate Structure for Services Provided in a Group Setting. Current Medicaid HCB services provided in a group setting are largely reimbursed based on a constant per-client basis, which does not appear to take into account the costs faced by providers in different situations. For example, congregate residential providers are reimbursed on a constant per-client basis regardless of a client's health acuity needs, the level of assistance needed by the client, or the situation in which services are delivered. While there are two rates for day support based on client need, each rate is still a constant per-client amount. Therefore, rates for congregate residential and day support services appear too low in some situations, adequate in others, and too high in still other situations.

Congregate residential support services give an example of how the adequacy of rates for services provided in a group setting can change depending on staff-to-client ratios. The per-recipient reimbursement rate for congregate residential care is a constant $13.45 per hour. However, if the staff-to-client ratio varies, the amount of reimbursement the provider actually receives per hour also varies. For instance, if a recipient requires the full attention of a direct care worker at all times, the staff-to-client ratio would be one-to-one, and the reimbursement rate the provider would receive would be $13.45 per *direct care worker* hour. However, in situations where one direct care worker is caring for two recipients at the same time, the provider would receive $26.90 per *direct care worker* hour (because the provider is being reimbursed for two recipient hours for every hour of direct care staff time). Likewise, if the staff-to-client ratios were one-to-three or one-to-four, the provider would receive $40.35 and $53.80 per direct care worker hour, respectively.

Table 16 shows how the varying levels of provider reimbursement compare to estimated costs using the living wage approach and the comparable position approach. If the staff-to-client ratio is one-to-one, the Medicaid reimbursement amount is below estimated costs using the living wage and comparable position approach. However, if the staff to client ratio is one-to-two, the Medicaid reimbursement is significantly above the living wage approach, but in the range of the comparable position approach. If the staff to client ratio is one-to-three or one-to-four, the Medicaid reimbursement exceeds by a substantial amount estimated provider costs under both the living wage approach and the comparable position approach.

This analysis is even more complex for day support services. In addition to variations in the staff-to-client ratios, day support can be reimbursed at either a regular or a high intensity rate. The high intensity rate is for recipients who require more physical assistance to meet personal care needs or who require constant support due to behavioral issues. Day support is also reimbursed on a unit basis rather than an hourly basis, which complicates this comparison further. Each unit corre-

Table 16

Comparison of Medicaid Rates with Estimated Costs Using the Living Wage and Comparable Positions Approaches:

Congregate Residential Services

	Medicaid Rate (FY 2006)		Living Wage Approach				Comparable Positions Approach			
Assumed Staff:Client Ratio	Per Recipient Rate	Provider Reimbursement Amount	Direct Care Workers' Hourly Wage	Direct Care Workers' Fringes	Supervision, Admin. & Overhead	Sum of Cost Components	Direct Care Workers' Hourly Wage	Direct Care Workers' Fringes	Supervision, Admin. & Overhead	Sum of Cost Components
1:1	$13.45	$13.45	$8.71	$2.96	$379	$15.46	$10.55	$7.08	$4.59	$22.22
1:2	13.45	26.90	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
1:3	13.45	40.35	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
1:4	13.45	53.80	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
1:1 (NoVa)	13.45	13.45	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
1:2 (NoVa)	13.45	26.90	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
1:3 (NoVa)	13.45	40.35	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
1:4 (NoVa)	13.45	53.80	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86

Source: JLARC staff analysis.

sponds to a major portion of the day (for example, a morning or afternoon) and is defined by DMAS as ranging from one to 3.99 hours.

With all of these permutations, there is wide variation in reimbursement levels that day support providers receive per direct care staff hour, which indicates that constant per-recipient amounts may not accurately reimburse providers for their costs. In some situations, the reimbursement rates may be inadequate, and in others they may be more than sufficient. It is unrealistic to expect the different reimbursement levels to average out to accurately match provider's costs. A detailed example of the varying reimbursement levels possible under the current day support rate structure is shown in Appendix E.

While the State could increase existing rates for services provided in a group setting using the current rate structure, so that they at least match the costs in every possible situation, this may result in reimbursement levels that are substantially above providers' costs in other situations. Therefore, a more prudent approach would be to review alternative rate structures to determine whether it is appropriate for Virginia to adopt a revised rate structure that more closely aligns reimbursement rates with the level of service provided in these settings.

Other States May Provide a Model for How Virginia Could Modify Its Rate Structure. As previously indicated, of the states reviewed for this study, Virginia was one of the few that does not adjust its rates for group MR and DD waiver services based on factors such as client health acuity and staffing ratios. Although Virginia does have separate high intensity and regular intensity rates for day support, other states appear to have much more detailed levels to categorize client need. For example, in Maryland each client is rated, using a standard assessment instrument, on his medical fragility and the level of assistance needed with basic living skills across five different levels. As the levels of medical fragility and need for assistance grow, the reimbursement rate grows as well. In Illinois, rates are adjusted based on staffing ratios assumed for different sized settings and client need. As client need increases, assumed staffing levels increase. Further, in many states the reimbursement rate for each additional client decreases as client to staff ratios increase, reflecting the decreased marginal cost of each additional client.

The actual reimbursement rates provided by other states may not be superior to Virginia's, because rates in other states generally were developed based on budgetary considerations (as is the case in Virginia) rather than an assessment of provider costs. However, their rate structures may provide a model for how Virginia could revise its current approach for reimbursing HCB services provided in a group setting. Therefore, it seems appropriate for a working group to review alternative rate structures for waiver services provided in group settings to determine whether the State could adopt a structure that more directly links reimbursement rates to the level of service provided.

Include General Supervision as a Billable Service Under Congregate Residential Support

Current DMAS regulations allow congregate residential support providers to bill for certain activities, such as training, assistance, and specialized supervision. However, providers are prohibited from billing Medicaid for other services, including "general supervision." (General supervision is, most frequently, overnight supervision of group home residents.) According to DMAS staff, this requirement is based on federal guidelines from the U.S. Centers for Medicaid and Medicare Services (CMS). However, possible changes to those guidelines may allow DMAS to begin reimbursing providers for general supervision costs.

As mentioned in Chapter I, congregate residential support services are residential support services that are typically provided in a group setting, such as a group home. During the week, congregate residential support is most frequently provided during the morning and evening before a recipient goes to day support and after he returns home. Providers can only bill for the number of hours that are approved in a resident's individualized service plan (ISP). However, most individuals receive six to eight hours of congregate residential support a day during the week. Over the weekend, providers may bill for up to 16 hours of support a day, depending on a resident's ISP, because individuals do not go to day support.

DMAS regulations prohibit providers from billing for the costs of room and board, and general supervision as part of congregate residential services. DMAS staff indicate that these regulations are based on federal guidelines from CMS. Specifically, the CMS guidelines state that "payments are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modification or adaptation to a facility required to assure the health and safety of residents, or to meet the requirement of the applicable life safety code." In other words, payments cannot be made for routine room and board costs. The CMS guidelines further indicate that payments cannot be made to "members of an individual's immediate family" or "for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid." DMAS has interpreted the requirement relating to "routine care and supervision" to mean general supervision activities, such as overnight supervision.

Providers indicate that even though they are unable to bill for general supervision, they must provide an adequate level of staff support during these times in case problems arise. Rules and regulations for the licensing of congregate residential settings, which is overseen by the Department of Mental Health, Mental Retardation, and Substance Abuse Service (DMHMRSAS), also seem to indicate that 24-hour care is expected in congregate residential settings. However, providers indicate that because they are unable to bill Medicaid for these costs, they often go unreimbursed.

Possible forthcoming changes to CMS guidelines regarding congregate residential support services may allow DMAS to begin reimbursing providers for general supervision costs. CMS is currently in the process of revising its application for

Medicaid HCB waiver services, and the most recent CMS draft service definitions for congregate residential support services appear to have dropped the requirement that payment may not be made for "routine care or supervision." If this is the case, it appears the State would have the option to begin reimbursing providers for general supervision costs.

Two factors should be kept in mind when considering the issue of general supervision. One is that, as mentioned in the previous section, congregate residential providers may receive a reimbursement level that is greater than their costs if they are providing services in larger client-to-staff ratios. Although Medicaid funds are only supposed to be used for Medicaid direct care purposes, it is possible that in practice, providers are using any excess reimbursement to cover general supervision costs. Further, providers can bill for "specialized supervision" during typical general supervision times, if an individual's ISP indicates a need for specialized supervision for health and safety reasons. For example, an individual's ISP may call for specialized night supervision if an individual has uncontrolled seizure disorder.

The cost of reimbursing congregate residential providers for general supervision activities could be significant depending on the proportion of providers' overall operating costs that are categorized as general supervision. Several providers reported to JLARC staff that their general supervision costs ranged from 42 percent of their total operating costs (not including room and board) to less than one percent of total operating costs.

Due to the previously mentioned problems with the rate structure for congregate residential services and the unknown amount of unreimbursed costs for general supervision, any consideration of including general supervision should be carried out in conjunction with a review of the overall rate structure for services provided in a group setting. It may be most appropriate for a working group to address these issues further. This working group could include relevant State agencies, HCB service providers, recipients of Medicaid waiver services, and relevant provider and recipient associations.

Appendixes

Appendix A

Study Mandate

Item 21 #1c of the 2005 Appropriation Act

E. The Joint Legislative Audit and Review Commission (JLARC) shall report on the adequacy of Virginia's Medicaid reimbursement rates to health care providers. The review shall include an examination of the impact of reimbursement levels on access to care for the Medicaid recipient population. This review shall cover home and community-based care providers. The Department of Medical Assistance Services shall cooperate fully as requested by JLARC and its staff. JLARC shall report its findings and recommendations by November 1, 2005.

Appendix B

Glossary of Waiver Services

Adult Companion Care: "Companion services" means nonmedical care, support, and socialization provided to an individual age 18 and over. The provision of companion services does not entail hands-on nursing care, but it is not purely diversional in nature. It is provided in accordance with a therapeutic goal in the consumer service plan, as dictated by the individual's health care and support needs.

Adult Day Health Care: Services offered to recipients in a congregate daytime setting where a group of professionals and aides provide personal care, socialization, nursing, rehabilitation, and transportation services.

Assistive Technology: Equipment, devices, and supplies that enable individuals to increase their abilities to perform activities of daily living, or aid the individual in communicating, and which are necessary to maintain the individual at home.

Case Management: Monitoring, reevaluation, revisions to the plan of care, and integration of services provided to recipient.

Congregate Residential: Training, assistance or specialized supervision provided primarily in a licensed or approved residence to enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. This service is provided to enable individuals to maintain or improve their health, to develop skills in activities of daily living, to adapt their behavior to community and home-like environments, to develop relationships, and participate as citizens in the community. In order to qualify for this service in a congregate setting, the individual has a demonstrated need to continuous training, assistance, and supervision for up to 24 hours per day provided by a Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)-licensed residential provider.

Consumer-Directed Services: Services for which the recipient or family/caregiver is responsible for hiring, training, supervising, and firing of the staff.

Crisis Stabilization: Direct intervention to persons with mental retardation who are experiencing serious psychiatric or behavioral challenges that jeopardize their community living situation, by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service is designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

Day Support: Training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typi-

cally take place outside the home in which the individual resides. Day support services focus on enabling the individual to attain or maintain his maximum functional level.

Environmental Modifications: Physical adaptations to a house, place of residence, or vehicle that ensure the individual's health and safety, or enable functioning with greater independence.

Family/Caregiver Training: Family/caregiver training is the provision of identified training and education related to disabilities, community integration, family dynamics, stress management, behavior interventions and mental health to a parent, other family members or primary caregiver.

In-Home Residential: Support provided in the individual's home by a DMHMRSAS-licensed residential provider or a Department of Social Services (DSS)-approved provider of adult foster care services. This service includes training, assistance or specialized supervision that is provided to enable individuals to maintain or improve their health, to develop skills in activities of daily living, to adapt their behavior to community and home-like environments, to develop relationships, and participate as citizens in the community.

Medication Monitoring: An electronic device that reminds recipients to take their medications at the correct dosages and times.

Nutritional Supplements: In cases of the AIDS waiver, a physician may order nutritional supplements when the individual requires it as the primary source of nutrition and is not able to purchase it through other available means. Due to the prevalence of conditions of wasting, malnutrition and dehydration, many individuals with AIDS or ARC require nutritional supplements as a component of their health care plan.

Personal Care: Long-term maintenance or support services necessary to enable the recipient to remain at or return home rather than enter a nursing care facility. Personal Care Aides assist with the recipient's activities of daily living (ADLs), such as bathing, dressing, transferring, and meal preparation.

Personal Emergency Response System (PERS): An electronic device that enables certain recipients at high risk of institutionalization to secure help in an emergency through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line.

Private Duty Nursing / Skilled Nursing: Care provided by a Registered Nurse or a Licensed Practical Nurse. These services are ordered by a physician and required to prevent institutionalization.

Respite Care: Services specifically designed to provide a temporary, but periodic or routine, relief to the primary unpaid caregiver of an individual who is incapacitated

or dependent due to frailty or physical disability. Respite care services include assistance with personal hygiene, nutritional support, and environmental maintenance authorized as episodic, temporary relief, or as a routine periodic relief of the caregiver.

Supported Employment: Work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with mental retardation to maintain paid employment.

Therapeutic Consultation: Activities to assist the individual, family/caregiver, staff or residential support, day support, and any other providers in implementing an individual service plan.

Appendix C

Distribution of Recipients of Major Medicaid Waiver Services and Payments of Other Services

LOCALITY	PERSONAL CARE recipients per 1000 poverty population	RESPITE CARE recipients per 1000 poverty population	NURSING CARE recipients per 1000 poverty population	CONGREGATE RESIDENTIAL recipients per 1000 total population	IN-HOME RESIDENTIAL recipients per 1000 total population	DAY SUPPORT recipients per 1000 total population	OTHER SERVICES payments per capita (total population)
Accomack	28.2852	3.8303	0.1473	0.4910	0.1550	1.2145	1.2362
Albemarle	12.6147	3.8226	1.5291	0.1998	0.0999	0.2664	0.8435
Alleghany	43.7611	21.2892	0.0000	0.2367	0.4734	0.8876	2.2665
Amelia	32.7004	15.8228	2.1097	0.9167	0.0833	1.0833	3.1113
Amherst	25.9419	12.3533	0.3088	1.3782	0.3846	1.4423	3.0483
Appomattox	34.9063	18.7460	0.0000	0.8029	0.1460	1.0949	2.1839
Arlington	6.7497	2.3659	0.7654	0.2329	0.0466	0.2019	1.4333
Augusta	22.5237	8.6839	3.2564	0.6953	0.2071	0.3994	2.4045
Bath	15.5039	2.5840	0.0000	1.2500	0.0000	1.2500	1.7333
Bedford County	18.0624	9.6176	0.4692	0.9410	0.1914	0.7656	2.3281
Bland	19.5313	6.5104	1.3021	0.0000	0.7143	0.1429	0.8623
Botetourt	6.4144	1.2829	0.0000	0.1592	0.1911	0.2866	0.5590
Brunswick	64.4783	17.5850	1.1723	0.4372	0.0000	2.0219	4.0035
Buchanan	14.4054	4.0201	1.5075	0.0395	0.4743	0.4743	1.3755
Buckingham	34.8184	4.1183	0.0000	0.2500	0.0000	0.2500	1.4974
Campbell	26.8343	15.0122	2.6271	0.8481	0.4931	0.6706	3.0252
Caroline	19.9203	7.9681	3.4861	0.3830	0.2979	0.8085	2.5684
Carroll	30.0856	9.1085	1.3801	0.2694	0.4714	0.8754	1.8232
Charles City	14.9660	6.8027	2.7211	0.1429	0.0000	0.5714	3.8376
Charlotte	26.9300	10.3232	0.4488	0.8871	0.0000	1.2903	3.4305
Chesterfield	22.1819	12.9467	5.0060	0.6719	0.1422	0.7110	5.8597
Clarke	12.3305	4.9322	0.0000	0.4380	0.0730	0.3650	0.9120
Craig	1.9231	0.0000	0.0000	0.1923	0.0000	0.1923	0.3745
Culpeper	15.4207	3.3523	1.3409	0.6394	0.5115	1.2276	1.2436
Cumberland	36.0294	7.3529	0.0000	0.6316	0.0000	1.1579	3.5537
Dickenson	42.7746	15.8960	0.0000	0.3659	0.0000	0.9756	3.8195
Dinwiddie	59.9542	15.5606	0.0000	0.7874	0.0394	0.5906	1.6462
Essex	65.0779	21.9982	0.9166	0.3960	0.0000	1.0891	1.5446
Fairfax County	9.5400	3.9635	2.0509	0.2809	0.0625	0.3276	1.8904
Fauquier	11.1336	2.6991	0.3374	0.3415	0.0488	0.6179	0.4872
Floyd	16.7079	7.4257	2.4752	1.2329	0.7534	0.6849	2.5473
Fluvanna	19.6253	8.0285	0.0000	0.0000	0.0823	0.0412	1.1462
Franklin County	10.0424	4.4633	2.0085	0.3441	0.1619	0.4858	0.8573
Frederick	9.6592	3.4881	2.4148	0.6938	0.0603	0.5732	1.5714
Giles	17.0670	12.0101	0.0000	0.9202	0.3067	0.7362	3.2755

Appendix C

Distribution of Recipients of Major Medicaid Waiver Services and Payments of Other Services

LOCALITY	PERSONAL CARE recipients per 1000 poverty population	RESPITE CARE recipients per 1000 poverty population	NURSING CARE recipients per 1000 poverty population	CONGREGATE RESIDENTIAL recipients per 1000 total population	IN-HOME RESIDENTIAL recipients per 1000 total population	DAY SUPPORT recipients per 1000 total population	OTHER SERVICES payments per capita (total population)
Gloucester	31.7700	15.1286	0.7564	0.2557	0.1989	0.7386	2.4515
Goochland	13.1086	5.6180	0.0000	0.2151	0.5376	0.6452	2.2123
Grayson	46.4912	9.2105	0.0000	0.6587	0.3593	0.9581	2.7270
Greene	30.3951	6.0790	6.0790	0.0599	0.3593	0.2994	1.0015
Greensville	50.5213	17.6423	0.0000	0.5128	0.0000	0.6838	0.7936
Halifax	22.5092	6.9796	0.5235	0.3857	0.0826	1.2672	2.3828
Hanover	31.3214	15.6607	3.2626	0.5169	0.3059	0.6224	2.3435
Henrico	28.4601	10.3034	3.7067	0.4149	0.0751	0.5436	2.3011
Henry	21.4104	4.3420	1.7967	0.3630	0.1815	0.6171	1.2465
Highland	18.8679	6.2893	0.0000	1.2500	1.2500	2.5000	5.3406
Isle Of Wight	64.9245	2.8583	0.0000	0.2556	0.0958	0.3195	0.8968
James City	15.9947	11.3296	0.0000	0.0906	0.0000	0.3623	0.5790
King And Queen	56.1010	28.0505	1.4025	0.1493	0.0000	1.0448	2.1416
King George	15.2672	5.4526	5.4526	0.4188	0.2094	0.4712	6.6976
King William	42.0757	19.6353	0.0000	0.2143	0.0000	0.9286	1.1882
Lancaster	30.7362	12.1515	0.0000	0.5310	0.3540	0.7965	1.1604
Lee	28.2749	9.3057	1.0737	0.1575	0.0787	0.1575	1.2089
Loudoun	7.3323	3.2349	3.2349	0.1944	0.0248	0.1199	1.6905
Louisa	32.8693	4.2537	1.1601	0.2878	0.0360	0.3237	2.1830
Lunenburg	36.6008	12.2003	0.4207	0.6870	0.0000	0.8397	2.0977
Madison	4.2409	0.0000	3.3927	0.3008	0.0752	0.6015	0.5083
Mathews	41.8182	16.3636	0.0000	0.7447	0.1064	1.2766	1.8080
Mecklenburg	35.9457	10.2403	1.2539	0.4644	0.0929	1.2693	3.9769
Middlesex	25.5795	11.9904	3.1974	0.9901	0.0990	1.4851	2.1227
Montgomery	4.2673	2.5950	0.5190	0.2907	0.3605	0.1977	0.9930
Nelson	15.4905	6.3110	0.0000	0.2013	0.0671	0.3356	0.2443
New Kent	18.6335	9.3168	0.0000	0.2703	0.0000	0.4054	1.2505
Northampton	55.8299	5.6969	0.0000	0.1550	0.3876	2.3256	3.0771
Northumberland	40.5316	11.9601	1.3289	0.4762	0.0794	0.8730	1.8930
Nottoway	29.0883	9.9326	0.7095	0.3871	0.0000	0.9032	2.7447
Orange	23.2058	3.0082	0.4297	0.3860	0.1754	0.8070	0.9768
Page	16.8717	7.7329	1.7575	0.2954	0.0000	0.2954	1.4533
Patrick	10.8865	1.5552	1.9440	0.4688	0.2083	0.9896	1.5859
Pittsylvania	28.8208	6.0967	0.5542	0.3094	0.2769	0.5049	1.7650
Powhatan	23.8305	6.1783	0.0000	0.3543	0.1969	0.5118	0.9376

Appendix C

Distribution of Recipients of Major Medicaid Waiver Services and Payments of Other Services

LOCALITY	PERSONAL CARE recipients per 1000 poverty population	RESPITE CARE recipients per 1000 poverty population	NURSING CARE recipients per 1000 poverty population	CONGREGATE RESIDENTIAL recipients per 1000 total population	IN-HOME RESIDENTIAL recipients per 1000 total population	DAY SUPPORT recipients per 1000 total population	OTHER SERVICES payments per capita (total population)
Prince Edward	21.9051	9.2931	0.0000	0.7960	0.1493	1.4925	5.8132
Prince George	20.1432	10.2954	2.2381	0.0000	0.0000	0.0545	0.2014
Prince William	19.0445	7.1417	1.5597	0.2529	0.0320	0.3169	0.8032
Pulaski	7.6508	3.6004	0.2250	0.2346	0.2053	0.3519	0.8941
Rappahannock	5.6604	1.8868	0.0000	0.0000	0.0000	0.0000	0.0000
Richmond County	20.1465	12.8205	3.6630	0.3191	0.1064	0.5319	1.0787
Roanoke County	11.2540	4.0193	1.6077	0.6122	0.2494	0.7937	1.3413
Rockbridge	35.4251	18.2186	2.0243	0.8491	0.1415	1.0849	4.1831
Rockingham	16.4358	7.2022	2.5854	0.9943	0.0994	0.9659	2.6021
Russell	28.5593	6.9812	1.2693	0.6463	0.5102	1.0884	3.2082
Scott	13.3952	6.9552	0.0000	0.4741	0.4741	0.4310	1.7687
Shenandoah	12.6895	4.5823	1.4099	0.6527	0.0522	0.1044	1.5321
Smyth	44.5786	4.6436	0.0000	0.4954	0.3715	0.8359	1.7544
Southampton	42.5163	3.9046	0.0000	0.0562	0.1124	0.0562	0.2963
Spotsylvania	12.0085	3.5319	2.5901	0.2500	0.1339	0.3571	1.3825
Stafford	14.0217	5.0988	2.5494	0.1915	0.1218	0.2611	1.2329
Surry	35.4223	6.8120	0.0000	0.2941	0.0000	0.4412	0.6964
Sussex	70.7577	21.2899	0.0000	2.5620	0.3306	3.0579	3.4694
Tazewell	18.6971	6.3808	2.8194	0.5467	0.3189	0.8428	1.5542
Warren	3.8008	0.3801	2.2805	0.3540	0.0590	0.3245	0.7466
Washington	19.2026	4.5721	0.7315	0.1949	0.2144	0.7018	1.3941
Westmoreland	23.0074	8.6278	0.0000	0.2439	0.0000	0.5488	0.8408
Wise	29.6410	9.3267	1.0221	0.8252	0.2427	1.0437	2.5654
Wythe	29.3236	5.3316	2.6658	0.8364	0.4364	0.9818	3.4407
York	19.0036	11.2994	1.5408	0.1951	0.0488	0.4390	0.6604
Alexandria	8.6887	3.0145	0.2660	0.3428	0.0671	0.4247	1.2255
Bedford City	11.2069	4.3103	0.0000	1.1111	0.3175	1.1111	4.4110
Bristol	9.9448	1.4733	1.1050	0.8721	0.2907	0.9884	2.5217
Buena Vista	33.4928	9.5694	0.0000	0.3125	0.1563	0.9375	1.4297
Charlottesville	4.6231	1.5075	0.7035	2.3038	0.3544	2.4810	3.8015
Chesapeake	18.0938	7.0131	0.9818	0.2194	0.2098	0.2337	0.8331
Colonial Heights	41.6210	13.1435	0.0000	0.0588	0.0588	0.1765	0.2488
Covington	23.5732	18.6104	0.0000	0.1695	1.3559	1.5254	2.8246
Danville	24.0154	1.8145	0.1067	1.5033	0.1307	1.1765	3.5642
Emporia	52.9344	13.8090	0.0000	0.7273	0.0000	0.7273	1.1345

Appendix C

Distribution of Recipients of Major Medicaid Waiver Services and Payments of Other Services

LOCALITY	PERSONAL CARE recipients per 1000 poverty population	RESPITE CARE recipients per 1000 poverty population	NURSING CARE recipients per 1000 poverty population	CONGREGATE RESIDENTIAL recipients per 1000 total population	IN-HOME RESIDENTIAL recipients per 1000 total population	DAY SUPPORT recipients per 1000 total population	OTHER SERVICES payments per capita (total population)
Fairfax City	2.4896	2.4896	0.0000	0.3004	0.0429	0.1717	1.9988
Falls Church	2.3148	0.0000	0.0000	0.3571	0.0000	0.2679	0.4179
Franklin City	18.7500	1.2500	0.0000	0.2439	0.6098	0.6098	1.7756
Fredericksburg	9.8784	2.2796	1.5198	1.3270	0.7109	0.9479	5.4035
Galax	32.9317	10.4418	0.0000	1.9118	0.5882	2.3529	5.0909
Hampton	16.1718	7.2906	0.5302	0.5182	0.1471	0.7983	1.7640
Harrisonburg	4.8907	1.6968	0.4991	0.2810	0.3044	0.5855	2.2060
Hopewell	17.7751	5.2099	0.3065	0.0450	0.0000	0.0901	8.8515
Lexington	20.1005	3.0151	0.0000	0.8696	0.1449	0.7246	2.0304
Lynchburg	14.5253	5.5538	0.5340	0.7025	0.3886	0.9567	2.5500
Manassas	16.7364	5.5788	0.0000	0.5946	0.0541	0.5946	0.8247
Manassas Park	9.4340	5.6604	1.8868	0.0806	0.1613	0.3226	0.5732
Martinsville	15.8507	3.8746	0.7045	1.5646	0.0680	1.1565	2.7119
Newport News	11.5287	3.1631	0.0832	0.4002	0.1425	0.6305	1.6640
Norfolk	16.3497	5.0909	0.4895	0.2053	0.4363	0.4962	1.7664
Norton	34.2466	13.6986	0.0000	0.2564	0.2564	0.0000	0.7191
Petersburg	42.5631	12.8463	0.4643	1.2381	0.2222	1.0794	10.0710
Poquoson	17.5781	3.9063	0.0000	0.0862	0.0000	0.2586	0.2017
Portsmouth	23.5925	6.9162	0.2585	1.1861	0.5112	1.5542	3.6966
Radford	2.4390	1.7073	0.0000	0.5263	0.1974	0.5921	1.0883
Richmond City	22.8195	6.9927	1.4682	0.7672	0.0570	0.8605	6.4576
Roanoke City	6.6924	1.4872	1.6900	0.6263	0.3348	1.1123	2.7749
Salem	5.1780	1.2945	3.2362	0.2439	0.0407	0.4065	0.3171
Staunton	12.8773	5.2314	0.4024	1.2389	0.9292	1.1062	4.6126
Suffolk	40.7793	6.5344	0.8470	0.4106	0.2914	0.4901	1.0787
Virginia Beach	13.7319	6.2953	1.6567	0.5459	0.3215	0.6107	2.1037
Waynesboro	28.0602	5.6934	5.2867	1.1616	0.5051	0.9091	4.4893
Williamsburg	10.2866	5.8780	0.0000	0.0000	0.0000	0.1471	0.3713
Winchester	4.3464	1.0030	4.3464	0.9804	0.1569	1.0196	2.2851
Statewide average:	19.2190	6.2195	1.2183	0.4521	0.1716	0.5787	2.1298

Appendix D

Estimating the Key Cost Components Using the "Comparable Position" and "Living Wage" Approaches

There are several possible approaches to estimating the key cost components of providing Medicaid home and community-based services. This study used both a "comparable position" approach and a "living wage" approach to illustrate potential provider costs. The "comparable position" approach produces personnel costs that are more competitive with the job market, while the "living wage" approach produces lower personnel costs.

THE COMPARABLE POSITION APPROACH

Cost estimates based on the comparable position approach can be considered to represent the high end of the range of possible cost estimates for two reasons. One reason is that the hourly wages are based on what the State or nursing homes pay staff in comparable positions in order to compete in the labor market as employers hiring and retaining staff. The second reason is that the fringe benefits package is also a key part of the compensation package that is used by the State to be competitive in hiring and retaining staff, so it tends to be higher than that assumed under the living wage approach.

Hourly Wages Based on Those Paid for Comparable Positions

Average wages were derived for workers in positions comparable to staff who work directly with recipients of the six largest Medicaid waiver services in terms of spending. In particular, the State employs workers in positions comparable to direct support employees in four of these six service types. As of November 25, 2004, the State employed 4,193 Direct Service Associates, 578 Licensed Practical Nurses (LPNs), and 1,305 Registered Nurses (RNs) who were in non-managerial positions.

The vast majority of the State's Direct Service Associates worked in Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities. Their duties were comparable to those of direct support staff providing day support, congregate residential, and in-home residential services. On average, the State paid them $10.55 an hour in most parts of the State, and $11.50 in Northern Virginia.

The State LPN and RN positions were comparable to those providing private duty and skilled nursing services. On average, the State paid LPNs $14.57 per hour except in Northern Virginia, where the average wage was $16.65 per hour. Likewise, the State paid RNs an average of $21.69 per hour except in Northern Virginia, where they were paid an average of $24.79 per hour.

The positions most comparable to direct support staff providing personal care and respite care services were those of nurse aides in nursing homes. According to the most recent survey of nursing homes in Virginia conducted by the Department of Medical Assistance Services (DMAS), nurse aides were paid an average of $11.42 per hour across the entire State. The Northern Virginia average wage was $13.10 per hour, while in the rest of the State the average wage was $11.10 per hour.

Fringe Benefit Costs and Supervisory, Administrative and Overhead Costs

In addition to wage costs for direct care workers, providers incur fringe benefit costs and supervisory, administrative, and overhead costs. A key part of the compensation package for State employees is the fringe benefits. This package includes employer contributions to Social Security, a retirement plan (the Virginia Retirement System, or VRS), group life insurance, health insurance, and paid leave. The current rates for Social Security, VRS, and group life insurance are 7.65, 4.83 and 0.32 percent of wages, respectively.

The average premium for health insurance paid by the State is $6,208 annually, or $2.98 per hour. It is a weighted average of three types of coverage available to State employees: single ($4,080 per year), dual ($7,272 per year), and family ($10,668 per year). The weights are the distribution of the State work force among the plan types: 57.8 percent single coverage, 19.2 percent dual coverage, and 23.0 percent family coverage.

An additional benefit that the State provides is paid time off for its employees. Without paid leave, the total number of working hours in a year would be 2,080 (52 weeks times 40 hours per week). Each year the State provides 12 days of holiday leave, at least 12 days of annual or vacation leave, ten days of sick leave, at least four days of family sick or personal leave, and two days of community service leave. This paid leave totals to at least 320 hours per year, leaving the remaining working hours per year to be 1,760. The value of the paid leave itself is estimated as the hourly rate times 320, divided by the number of hours actually worked (1,760). Further, the hourly value of the other fringe benefits is increased by approximately 18 percent, because it can now be assumed that only 1,760 rather than 2,080 hours are worked.

Data on nurse aides' fringe benefits were included in the DMAS survey of nursing homes. Total fringe benefits were on average 28 percent of wages.

The rates for determining supervisory, administrative, and overhead costs in the comparable position approach are the same as those used for the living wage approach (which are explained in more detail below). The amounts for supervisory, administrative, and overhead costs may tend to be slightly higher under the comparable position approach because it is assumed that if the direct support staff are paid more, then their supervisors are paid more as well.

THE LIVING WAGE APPROACH

The estimates generated from the living wage approach can be considered to represent the lower end of the range of possible cost estimates for two reasons. First, this approach assumes that hourly wages are based on the minimum amount of income needed to live without having to rely on government assistance, regardless of what competitive wages may be in the marketplace. Second, this approach assumes that current practices of providers regarding fringe benefits are used, which would keep fringe benefit costs at a relatively lower level.

Hourly Wages Based on the Living Wage

A living wage has been defined in the literature in two main ways. First, it is defined as a wage that equates the pay rate between workers doing the same job and being paid with public dollars regardless of whether their employer is a public entity or a private contractor. For example, if a state government has a customer service center in which workers receive $10.50 per hour and then contracts with a private company to provide additional workers, the workers with the private company cannot be paid less than $10.50 per hour. Second, a living wage is defined as a pay rate which allows an individual to be self-sufficient in his or her environment. In this case, the living wage in Virginia is not the same as in North Carolina, the living wage in Norfolk is not the same as in Abingdon, and the living wage is not the same for a single mother of two as it is for a single, childless adult. The concept of a living wage has been codified by law in some Virginia communities and is a guiding principle in the Virginia Department of Social Service's efforts to move citizens off public assistance.

A living wage is distinct from the minimum wage. Unlike a living wage, the minimum wage is set by the federal government and is not based on a self-sufficiency standard or on keeping people out of poverty. For example, at the current minimum wage of $5.15 per hour, an individual working full-time (2080 hours per year) would make $10,712 in pre-tax income. Even with only a 15 percent reduction for taxes, that same individual would net only $9,105 per year, which is $465.00 less than the federal poverty level for one person (currently $9,570 per year).

In fact, the Department of Social Services recognizes this need for self-sufficiency in its 2004-2006 strategic plan. The department currently plans to use estimates in the *Self-Sufficiency Standard for Virginia* as benchmarks for determining the degree of financial independence of their clients. The *Self-Sufficiency Standard for Virginia* is the result of a study conducted by Diana Pearce, which was completed in July, 2002. (This report is on the website: http://www.vakids.org/Publications/SSS-VA%20Full%20Report%2-7-9.pdf). For each of Virginia's counties and cities, this study estimated several different income levels that would be needed for self-sufficiency, depending on family size and composition.

Based on the estimates in the *Self-Sufficiency Standard for Virginia,* JLARC staff calculated a weighted average living wage rate for each locality in Vir-

ginia that takes into account different family types. For each locality, living wage estimates were available for the following family composition types: (1) an adult with no children under age 18; (2) a single adult with two children; and (3) households with two adults and two children. A weighted average of these three living wage estimates was calculated, with the following weights: 0.6200 for adults with no children; 0.1167 for single adults with children; and 0.2632 for two-adult households with children. These weights are based on the assumption that the vast majority of direct care workers are women, and the proportions are derived from U.S. Bureau of Labor Statistics *Women in the Labor Force 2004* data on family composition characteristics of working women.

Local average living wages were substantially higher in Northern Virginia localities compared to localities in the rest of the State (see Figure 16 in Chapter III). Therefore, the average living wage in Northern Virginia localities was estimated to be $11.59, and $8.09 in the rest of the State. These numbers were based on 2002 data. Inflating these numbers to FY 2006 levels (using the Consumer Price Index of all items), the estimated living wage for Northern Virginia was $12.61, and $8.71 for the rest of the State.

Fringe Benefit Costs and Supervisory, Administrative and Overhead Costs

In addition to wages paid to direct care staff, providers also incur costs for fringe benefits and taxes for direct care staff, as well as supervisory, administrative, and direct and indirect non-personnel costs when providing services. While most of these costs are not directly related to providing care, they are legitimate costs that are required to run a business. Also, some supervisory costs, such as nurse supervisors for personal care attendants, are required by DMAS, even though providers are not able to bill for these activities. Although providers are only permitted to bill for direct hours or units of care provided, it seems appropriate for a reimbursement rate to recognize supervisory, administrative, and overhead costs.

Although it is generally recognized that HCB service providers incur costs for fringe benefits, supervision, administration, and overhead, there are no data on the extent of these costs for Virginia's HCB service providers. HCB service providers are not required to submit cost reports to the federal government, and the State does not collect these data. JLARC staff were advised that a statewide data collection effort across all providers would not be feasible due to the different approaches to maintaining financial data by providers. Furthermore, some providers were resistant to a statewide data collection effort because they felt such an exercise would only demonstrate what provider costs are given the current level of reimbursement, not what they should be.

Therefore, to estimate fringe benefit costs and costs for supervision, administration, and overhead, JLARC staff relied on studies of provider costs that were conducted in other states. North Carolina recently conducted a study of personal care provider costs, and Mercer Human Resource Consulting recently conducted a study for the state of Delaware of the costs of providing residential habilitation (which would be comparable to congregate residential services). JLARC

staff compared the results of these cost studies to cost data collected from a select number of Virginia providers, and found the studies' results to be consistent with costs incurred by Virginia providers. Consequently, the North Carolina and Mercer studies are the basis of the assumed fringe benefit and overhead costs incurred by Virginia providers for the purposes of this report.

In FY 2003, the Division of Medical Assistance in North Carolina audited the costs of 20 personal care providers. (One provider was eventually dropped due to unreasonably high costs.) Table D.1 represents the North Carolina providers' cost components as a portion of direct care staff salaries and wages. Based on the audits, fringe benefits and taxes for direct care staff are 16 percent of direct care salaries and wages, while supervision, administration, and overhead are 58 percent of direct care salaries and wages.

Based on a select number of Virginia personal care providers, it appears that the allocation of cost data from North Carolina is comparable to providers' costs in Virginia. The North Carolina audits indicate that approximately 60 percent of total provider costs are for direct care salary and wages, 10 percent of costs are for direct care fringe benefits and taxes, and 30 percent of total costs are for supervision, administration, and overhead. This allocation of costs is consistent with how costs are allocated for a select number of Virginia personal care providers reviewed by JLARC staff. Therefore, for purposes of this report, it is assumed that personal care providers in Virginia incur costs at the same rate as is indicated in Table D.1.

Table D.1

Cost Components As a Portion of Direct Care Staff Salaries and Wages

Personal Care

Cost Components	**% of Direct Care Staff Salaries & Wages:**
Fringe Benefits and Taxes for Direct Care Staff	16
Supervision, Administration, and Overhead	58

Source: JLARC staff analysis of data provided by the North Carolina Division of Medical Assistance.

In 2001, Delaware contracted with Mercer Human Resource Consulting to assess its current rate structure costs for several home and community-based services. As part of this study, Mercer conducted a financial analysis of residential habilitation services, referred to as congregate residential services in Virginia. Table D.2 represents the results of the Mercer financial analysis. Mercer found that fringe benefits and taxes are 34.0 percent of direct care salaries and wages, while supervi-

sion, administration, and overhead costs are 43.5 percent of direct care salaries and wages. Possible explanations for why supervision, administration, and overhead costs are only 43.5 percent of direct care salaries for congregate residential, whereas they are 58 percent for personal care, include: (1) congregate residential providers appear to pay their direct care staff substantially more, which means that other costs make up a comparatively smaller proportion of direct salaries and wages; and (2) personal care has nurse supervisor requirements that are not required of congregate residential providers.

Table D.2

Cost Components As a Portion of Direct Care Staff Salaries and Wages

Congregate Residential

Cost Components	% of Direct Care Staff Salaries & Wages:
Fringe Benefits and Taxes for Direct Care Staff	34.0
Supervision, Administration, and Overhead	43.5

Source: JLARC staff analysis of the *Final Report October 2004* prepared by Mercer Human Resource Consulting for the State of Delaware Division of Developmental Disabilities Services.

Based on a select number of Virginia congregate residential providers, it appears that the allocation of costs included in the Mercer report are comparable to those incurred by Virginia providers. The Mercer report indicates that approximately 55 percent of total provider costs are for direct care staff salaries and wages, 20 percent of costs are for direct care fringe benefits and overhead, and 25 percent of costs are for supervision, administration, and overhead. This allocation is consistent with the allocation of costs for a select number of Virginia congregate residential providers reviewed by JLARC staff. Therefore, for purposes of this report, it is assumed that congregate residential providers in Virginia incur costs at the same rate as is indicated in Table D.2.

JLARC staff were unable to find studies comparable to the North Carolina study or the Delaware study for private duty and skilled nursing, in-home residential, or day support providers. Although JLARC staff collected cost data from a small number of Virginia providers for each of these services, these data are not generalizable because they are based on too few providers. JLARC staff assumed the same allocation of costs for private duty and skilled nursing providers as for personal care providers because the services are similar and the same providers often offer both services. Likewise, JLARC staff assumed the same allocation of costs for day support and in-home residential services as for congregate residential providers

because the same providers often offer two, if not all three, of these services, and because cost data provided by Virginia day support providers indicate that the allocation of costs is very similar to congregate residential providers. An alternative estimate of supervision, administration, and overhead costs is also provided for in-home residential services to reflect relatively higher amounts for these costs that were reported by several Virginia providers. Because data was not collected from a large number of Virginia in-home residential providers, JLARC staff determined it was most appropriate to provide a range of costs for this service, rather than a single point estimate based on only the lower or higher amount.

Appendix E

Comparison of Medicaid Rates with Key Cost Components: Day Support Services

Service, Assumed Staff:Client Ratio	Medicaid Rate		Living Wage Approach				Comparable Positions Approach			
	Per Recipient Rate (Per Unit)	Provider Reimbursement Amount (Per Hour)	Direct Care Workers' Hourly Wage	Direct Care Workers' Fringes	Super-vision, Admin. & Overhead	Sum of Cost Components	Direct Care Workers' Hourly Wage	Direct Care Workers' Fringes	Super-vision, Admin. & Overhead	Sum of Cost Components
Regular Rate, 3.99 Hours per Unit										
Day Support 1:1	$25.19	$6.31	$8.71	$2.96	$379	$15.46	$10.55	$7.08	$4.59	$22.22
Day Support 1:2	25.19	12.63	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:3	25.19	18.94	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:4	25.19	25.25	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:1 (NoVa)	25.19	6.31	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:2 (NoVa)	25.19	12.63	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:3 (NoVa)	25.19	18.94	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:4 (NoVa)	25.19	25.25	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Regular Rate, 2.5 Hours per Unit										
Day Support 1:1	25.19	10.08	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:2	25.19	20.15	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:3	25.19	30.23	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22

Appendix E

Comparison of Medicaid Rates with Key Cost Components: Day Support Services

Service, Assumed Staff:Client Ratio	Medicaid Rate		Living Wage Approach				Comparable Positions Approach			
	Per Recipient Rate (Per Unit)	Provider Reimbursement Amount (Per Hour)	Direct Care Workers' Hourly Wage	Direct Care Workers' Fringes	Super-vision, Admin. & Overhead	Sum of Cost Components	Direct Care Workers' Hourly Wage	Direct Care Workers' Fringes	Super-vision, Admin. & Overhead	Sum of Cost Components
Day Support 1:4	$25.19	$40.30	$8.71	$2.96	$379	$15.46	$10.55	$7.08	$4.59	$22.22
Day Support 1:1 (NoVa)	25.19	10.08	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:2 (NoVa)	25.19	20.15	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:3 (NoVa)	25.19	30.23	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:4 (NoVa)	25.19	40.30	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Regular Rate, 1 Hour per Unit										
Day Support 1:1	25.19	25.19	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:2	25.19	50.38	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:3	25.19	75.57	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:4	25.19	100.76	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:1 (NoVa)	25.19	25.19	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:2 (NoVa)	25.19	50.38	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:3 (NoVa)	25.19	75.57	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:4 (NoVa)	25.19	100.76	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
High Intensity Rate, 3.99 Hours per Unit										

Appendix E

Comparison of Medicaid Rates with Key Cost Components: Day Support Services

	Medicaid Rate		Living Wage Approach				Comparable Positions Approach			
Service, Assumed Staff:Client Ratio	**Per Recipient Rate (Per Unit)**	**Provider Reimbursement Amount (Per Hour)**	**Direct Care Workers' Hourly Wage**	**Direct Care Workers' Fringes**	**Super-vision, Admin. & Overhead**	**Sum of Cost Components**	**Direct Care Workers' Hourly Wage**	**Direct Care Workers' Fringes**	**Super-vision, Admin. & Overhead**	**Sum of Cost Components**
Day Support 1:1	35.86	8.99	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:2	$35.86	$17.97	$8.71	$2.96	$379	$15.46	$10.55	$7.08	$4.59	$22.22
Day Support 1:3	35.86	26.96	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:4	35.86	35.95	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:1 (NoVa)	35.86	8.99	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:2 (NoVa)	35.86	17.97	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:3 (NoVa)	35.86	26.96	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:4 (NoVa)	35.86	35.26	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
High Intensity Rate, 2.5 Hours per Unit										
Day Support 1:1	35.86	14.34	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:2	35.86	28.69	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:3	35.86	43.03	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:4	35.86	57.38	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:1 (NoVa)	35.86	14.34	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:2 (NoVa)	35.86	28.69	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:3 (NoVa)	35.86	43.03	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:4 (NoVa)	35.86	57.38	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86

Appendix E

Comparison of Medicaid Rates with Key Cost Components: Day Support Services

Service, Assumed Staff:Client Ratio	Medicaid Rate		Living Wage Approach				Comparable Positions Approach			
	Per Recipient Rate (Per Unit)	Provider Reimbursement Amount (Per Hour)	Direct Care Workers' Hourly Wage	Direct Care Workers' Fringes	Super-vision, Admin. & Overhead	Sum of Cost Components	Direct Care Workers' Hourly Wage	Direct Care Workers' Fringes	Super-vision, Admin. & Overhead	Sum of Cost Components
High Intensity Rate, 1 Hour per Unit										
Day Support 1:1	$35.86	$35.86	$8.71	$2.96	$379	$15.46	$10.55	$7.08	$4.59	$22.22
Day Support 1:2	35.86	71.72	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:3	35.86	107.58	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:4	35.86	143.44	8.71	2.96	379	15.46	10.55	7.08	4.59	22.22
Day Support 1:1 (NoVa)	35.86	35.86	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:2 (NoVa)	35.86	71.72	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:3 (NoVa)	35.86	107.58	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86
Day Support 1:4 (NoVa)	35.86	143.44	12.61	4.29	5.49	22.38	12.05	7.57	5.24	24.86

Source: JLARC staff analysis

Appendix F

Agency Response

As a part of the extensive validation process, State agencies and other entities involved in a JLARC assessment effort are given the opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from comments provided by these entities have been made in this version of the report. This appendix contains the written response of the Department of Social Services.

COMMONWEALTH of VIRGINIA

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October 3, 2005

Mr. Phil A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100
910 Capitol Street
Richmond, Virginia 23219

Dear Phil:

I appreciate the opportunity to respond to JLARC's report on the reimbursement rates for Medicaid home and community-based care providers. Your staff is to be commended for their professionalism and attention to detail.

Your review is most timely given the national attention to questions around the issue of rebalancing Medicaid-financed long-term care to encourage greater use of home and community-based care services. Clearly the issue of rate adequacy for home and community based care providers is a key challenge that Virginia and other states must address as efforts are made to move this system of care away from more expensive institutional services. However, as acknowledged in your report, Virginia will have to proceed with caution in this area to ensure that policies designed to increase the use of community-based care do not have the unintended effect of simply adding costs to the Medicaid budget.

As the impetus for greater use of community-based care grows, we at DMAS look forward to continued work on this issue. This report will assist us in that effort.

Sincerely,

PWFinnerty

Patrick W. Finnerty

PWF/wmt

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