# COMMONWEALTH of VIRGINIA

## *Department of Medical Assistance Services*

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November 3, 2010

**MEMORANDUM**

TO: The Honorable Bob McDonnell
Governor

The Honorable Charles J. Colgan
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

The Honorable Benjamin L. Cline
Chairman, Joint Commission on Health Care

FROM: Gregg A. Pane, MD, MPA

SUBJECT: Report on the Delivery of Home and Community-Based Services through the Medicaid State Plan and the §1915(i) State Option Plan

House Joint Resolution No. 83 of the 2010 Virginia General Assembly requested that the Joint Legislative Audit and Review Commission study the potential costs and benefits of offering Medicaid home and community-based long-term care services (HCBS) through the State Plan for Medical Assistance. While the resolution was tabled in sub-committee, the Virginia Department of Medical Assistance Services (DMAS) agreed to study the potential implication of providing HCBS through the State Plan. Attached is the requested report.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

Enclosure

Cc: The Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources

# Delivery of Home and Community-Based Services through the Medicaid State Plan and the §1915(i) State Plan Option


**Department of Medical Assistance Services**

November 2010

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## Executive Summary

House Joint Resolution No. 83 of the 2010 Virginia General Assembly requested that the Joint Legislative Audit and Review Commission study the potential costs and benefits of offering Medicaid home and community-based long-term care services (HCBS) through the State Plan for Medical Assistance (Appendix A). While the resolution was tabled in sub-committee, the Virginia Department of Medical Assistance Services (DMAS) agreed to study the potential implication of providing HCBS through the State Plan.

The Virginia Department of Medical Assistance Services provides medical and long-term care services to over 900,000 Virginians. Over 27,745 of these individuals rely on Medicaid-funded HCBS to provide the long-term care services they need in order to remain in their homes and communities and avoid institutionalization. In Virginia, these supportive services are provided through §1915(c) HCBS waiver programs. §1915(c) waivers are available to Virginians through a special agreement between the Department and the Centers for Medicare and Medicaid Services (CMS).

§1915(c) waiver programs enable the Department to provide an array of services to Virginians with specific conditions, such as intellectual disabilities or HIV/AIDS, and provide general supportive services to individuals who are elderly or have physical disabilities. §1915(c) waiver programs, however, have significant limitations. This report highlights two specific limitations of the §1915(c) waiver programs: the requirement that individuals must qualify for institutional care before accessing HCBS; and, the significant administrative burden of maintaining federal authority for the §1915(c) waiver programs. The report further discusses whether the Commonwealth can resolve these limitations through alternatives such as providing HCBS services through the State Plan for Medical Assistance or utilizing the new §1915(i) State Plan Option which was recently allowed through changes in federal law.

After research and analysis on these alternatives, evaluation of Departmental budget projections, and conversations with staff from CMS, it is apparent that given the current fiscal climate, resolving challenges within the §1915(c) waiver programs by moving services to the State Plan or utilizing the §1915(i) State Plan Option is not likely. Unless further changes in federal law occur, the fiscal impact of such a move combined with the continued administrative requirements for the provision of these services leads DMAS to conclude that these options may be unattractive to the Commonwealth at this time.

## Introduction

In 2009, DMAS provided long-term care services to over 55,388 individuals through home and community-based or institutional care. In accord with national trends, Virginia Medicaid is the largest payer of long-term care services in the Commonwealth. In state fiscal year (SFY) 2009, the Department spent over $1.9 billion on long-term care services representing one-third of the DMAS budget.

Long-term care services provide assistance and support with activities such as dressing, bathing, and ambulation for individuals who are not able to manage these activities on their own. Individuals' needs vary greatly, but most need supportive services for an extended period of time and many individuals need support due to intellectual, developmental, or cognitive challenges.

Historically, individuals who needed long-term care services received them in an institutional setting, such as a nursing facility. This institutional bias has prevailed in the long-term care arena for years yet facilities are very costly and often not the individual's first choice when needing extended care. Most people would prefer to stay in their own homes and receive home-based services. Prior to 1981, however, there was virtually no federal support for non-institutional long-term care services. During the early 1980s, federal laws changed and states began to focus on rebalancing the existing institutional bias for long-term care services. In 1982, DMAS introduced its first §1915(c) waiver program, the Elderly and Disabled waiver. It was the second §1915(c) waiver approved by CMS in the country. This "waiver" program enabled individuals whose level of need qualified them for nursing facility care to choose to receive long-term care services in their homes instead of in facilities. §1915(c) waiver programs enable eligible Virginians to receive long-term care services in a less restrictive community setting and enable the Department to provide services in a more cost effective manner than if the individual had been placed in an institution.

Though waiver programs offer significant benefits to the Commonwealth, limitations exist. Several waivers require that individuals be placed on waiting lists before they can enroll, thereby delaying access to needed services. Some stakeholders feel that the amount and variety of services provided through the waiver programs is limited. In addition, Virginia has some of the most stringent long-term care qualification requirements in the country. Many individuals, therefore, who would benefit from assistance, are not able to receive these services in Virginia because their needs are not considered significant enough to qualify them for long-term care. Further, maintaining authority for the §1915(c) waiver programs is a significant administrative burden. It is questionable whether the demands that this places on staff is an optimal use of resources and whether resources could be better allocated to ensure quality and optional provision of services. These concerns are shared by states across the country.

This report focuses on ameliorating these limitations. There are two alternatives that the Department could use to overcome these challenges. The Department could obtain federal authority to add home and community-based services to the State Plan for Medical Assistance instead of providing them through §1915(c) authority; or the Department could obtain federal authority to operate a §1915(i) State Plan Option HCBS program. This report provides a discussion of providing HCBS through the State Plan for Medical Assistance or the §1915(i) State Plan Option, an analysis of recent Congressional action related to HCBS, the fiscal impact of implementing these alternatives, and an analysis of whether this would be beneficial for the Commonwealth.

## Background

This section of the report provides an overview on the administrative authority of the Virginia Medicaid program and a brief history and background of Virginia's home and community-based waivers.

### *Administrative Authority of the Virginia Medicaid Program: State Plan vs. Waivers*

State Plan Authority

The Virginia Medicaid program is authorized under Title XIX of the *Social Security Act*. It is an entitlement program that is financed by the state and federal governments and administered by the Department of Medical Assistance Services. In order for Virginia to receive federal funding for the Medicaid program, covered services must be approved through the Virginia State Plan for Medical Assistance. The State Plan serves as Virginia's contract with CMS and authorizes Virginia to receive Federal Financial Participation (FFP), also referred to as the federal "match."

Each state must cover federally designated mandatory services; however, each state may select optional services and subsequently contract with the federal government to authorize the provision of these optional services through the State Plan for Medical Assistance. All services included in the State Plan must be available in the same amount, duration, and scope to all Medicaid recipients. To add a service to the State Plan, the Department submits a State Plan Amendment to CMS. Once the Amendment is approved, it does not need to be renewed.

Sometimes, however, a state may want to target certain services to specific populations or provide a certain type of service in a specific geographic region. To accommodate this desire, the federal government allows states to "waive" the *Social Security Act* requirement that states must offer services in the same amount, duration, and scope to all recipients and allow a state to target services. The process through which a state can waive *Social Security Act* requirements, but still receive FFP, is through a Medicaid waiver.

The Virginia Medicaid program administers several different types of waivers. For example, a §1915(b) waiver grants authority for states to mandate enrollment into a certain program or to limit freedom of choice of providers. DMAS uses this type of waiver to operate its managed care program on a mandatory basis using DMAS-contracted managed care organizations. Virginia also uses an §1115 Health Insurance Flexibility and Accountability (HIFA) waiver to operate its FAMIS MOMS and FAMIS Select programs. This allows the Commonwealth to provide a targeted benefit package to these groups. The most well-known of the waiver programs are the §1915(c) waivers. These waivers enable the Commonwealth to target home and community-based long-term care services to specific populations.

Waiver Authority

In 1981, through the *Omnibus Budget Reconciliation Act,* Congress authorized the waiver of certain requirements in the *Social Security Act* to allow states the ability to support and finance Medicaid HCBS for individuals who would otherwise require care in an institutional setting. Like other Medicaid benefits, HCBS waivers are jointly funded by state and federal governments. HCBS waivers are intended to allow individuals to preserve their independence and choice by remaining in the community.

Additionally, state Medicaid programs are able to serve these recipients in a more cost effective manner than would be achieved through institutional placement. For example, in SFY 2008, the Commonwealth spent an average of $20,780 on HCBS for each Elderly or Disabled with Consumer Direction waiver participant compared to over $28,640 per year for each individual placed in a nursing facility. This difference is even more pronounced for individuals enrolled in the Intellectual Disabilities (ID) waiver. In SFY 2008, the cost of HCBS for ID waiver participants was $71,638 compared to $144,359 for each individual placed in an Intermediate Care Facility-Mental Retardation (ICF-MR).

Through §1915(c) waivers, states have the flexibility to design and implement each waiver program through the selection of services that best address the population that will be served through the waiver. As previously discussed, however, waiver programs have limitations. Over the past decade, Congress has attempted to resolve some of the challenges that states face in administering §1915(c) waivers.

Home and Community-Based Services Provided Through a §1915(c) Waiver

Nationally, as of 2007, there were over 300 HCBS waiver programs in operation with an average of six waivers per state. Florida and Colorado have the greatest numbers of waivers, having 13 and 12 respectively. Virginia operates seven §1915(c) HCBS long-term care waivers. §1915(c) waivers require states to demonstrate cost-effectiveness as compared to a specific institutional placement. Because of this cost-effectiveness requirement, Virginia was required to create separate waiver programs for each target population it chose to serve. For example, the alternative institutional placement for the Elderly or Disabled with Consumer Direction waiver is a nursing facility and the alternative institutional placement for the Intellectual Disabilities waiver is an ICF-MR.

To develop each of Virginia's waivers, the Department had to undergo a rigorous submission process. This process included working with numerous stakeholder groups and obtaining approval of an application that included services covered, service delivery processes, target populations, projected utilization for each service, oversight procedures, quality management protocols, and an assessment of available providers to ensure that the provider network would adequately meet the needs of the population. After an initial development period of three years where annual reviews are required, each waiver must be renewed every five years through a very extensive process. If Virginia wishes to change one of its waiver programs between renewal periods it must re-open its application with CMS to submit the changes. This process is somewhat risky as CMS does not just evaluate the requested change. It re-evaluates

the entire application. This can pose problems if CMS or Congress has recently changed requirements. CMS can require the Commonwealth to make significant changes to the waiver program, far beyond the initial change that was requested.

§1915(c) Medicaid waivers enable the Department to provide targeted long-term supports to some of Virginia's most vulnerable residents. Waivers allow the Department to provide extensive HCBS services to the individuals who need them the most in the most cost-effective way available at this point in time. Some states, however, have included some HCBS long-term care services in their State Plans. This enables anyone in the Medicaid program to have access to these services. To date, Virginia has not chosen to do this; however, it is currently an option available to states.

Home and Community-Based Services Provided under the State Plan

Virginia only provides home and community-based long-term care services through its waiver programs. In order for a Virginia Medicaid recipient to receive HCBS, he or she must qualify for and be enrolled in a waiver. To qualify for a waiver, individuals must be assessed as having the same level of needs as someone who qualifies to enter a long-term care facility such as a nursing facility or an ICF-MR and be at risk of facility placement.

Twenty-nine states offer at least one HCBS benefit through their State Plan. This enables individuals to receive HCBS before their needs progress to the level of qualifying them for care in a facility. The most frequently offered HCBS through the State Plan is personal care. Personal care covers the cost of an attendant to go to an individual's home on a regular basis and help with activities such as bathing, dressing, and grooming. Individuals must still qualify as having the need for this service; however, the threshold for qualifying is typically lower than the requirement for nursing facility care. Please see Appendix A for a comparison of select states' State Plan personal care and institutional level of care criteria.

**States that offer personal care through their State Plans include:**

| | | |
|---|---|---|
| Alaska | Louisiana | Montana |
| Arkansas | Maryland | North Carolina |
| California | Maine | Nebraska |
| District of Columbia | Michigan | New Jersey |
| Florida | Minnesota | New Mexico |
| Idaho | Missouri | Nevada |
| New York | South Dakota | Washington |
| Oklahoma | Texas | Wisconsin |
| Oregon | Utah | West Virginia |
| South Carolina | Vermont | |

The premise behind offering HCBS before an individual requires nursing facility care is that providing services to individuals who only need limited assistance helps them maintain their current level of functioning and delays or prevents incidents that would result in necessary institutionalization. For example, if a personal care attendant is available to provide assistance

with bathing to an individual struggling with balance issues, then the individual is much less likely to fall, suffer a fracture, and need costly long-term rehabilitation and possible permanent long-term care. Preventing injuries and helping individuals maintain their independence not only benefits individuals but it avoids or delays medical and long-term care costs associated with extensive and complex needs.

If these services are offered through the State Plan for Medical Assistance, they must be available to all Medicaid recipients in the same amount, duration, and scope – just like medical services are provided to all Medicaid recipients. States cannot target these services to specific populations, such as individuals over age 65 or those with developmental disabilities like they can through a waiver, and states cannot only provide the services to individuals with certain conditions, such as Alzheimer's disease, like is possible through a waiver. While an individual must meet established criteria in order to be eligible for the service, opening up eligibility criteria through the addition of services to the State Plan for Medical Assistance results in limited budget control.

It is difficult to predict the expected utilization of a new or expanded service. Based on utilization experience of personal care services in states that have less restrictive functional criteria requirements than Virginia, for example requiring assistance with only two activities of daily living instead of four, utilization of personal care is typically around 15% of the Aged, Blind, and Disabled (ABD) population.[1] Based on this assumption, if Virginia broadened its functional criteria, an additional 3,816 individuals would likely qualify to receive personal care. This would result in an additional expected expenditure of $92,003,495 in total funds ($46,001,747 in general funds) each year.

Several states that offer State Plan personal care, such as Texas and New Mexico, however, have seen their actual expenditures for this service far exceeded their initial projections. The number of participants in the Texas program increased 81 percent between 1999 and 2005[2] and the New Mexico program found that its expenditures per participant tripled from 2000 to 2002.[3] If Virginia chooses to offer personal care through its State Plan, it will want to ensure that a plan is in place to handle variances in projected demand and strong oversight and monitoring protocols exist to ensure that the program is optimally administered.

Over the long-term, however, expanded and earlier utilization of personal care would likely achieve savings in hospitalizations, emergency department use, and more intensive long-term care services since injuries and physical decline would be prevented or delayed. Long-term savings, however, are difficult to quantify and in the short-term, adding personal care services to the State Plan will require additional appropriations to the Department to cover the cost of this service.

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[1] Utilization assumptions taken from "Final Recommendation of the Iowa Medicaid Infrastructure Grant Work Group: Creation of a Medicaid Personal Assistance Service (PAS) State Plan Benefit" (August 2001), which was based on a consultant's assessment of PAS program utilization of 15% by SSI and Dual Eligibles (elderly and persons with disabilities) in the states of AK, ME, MA, and MO.

[2] *The Texas Medicaid State Plan Personal Care Services Program*, Martin Kitchner, et at., Center for Personal Assistance Services, University of California, San Francisco, July 2006.

[3] *The New Mexico State Plan Personal Care Services Program*, Martin Kitchner, et at., Center for Personal Assistance Services, University of California, San Francisco, April 2006.

While adding a HCBS benefit, such as personal care, to the State Plan offers many advantages including early access to services, a minimal administrative burden, and anticipated long-term savings, a significant disadvantage exists in that this would have a substantial up-front and ongoing fiscal impact. The fiscal impact and limited cost controls available are the leading reasons for why Virginia and many other states have not offered HCBS through their State Plans.

Over the past decade, federal laws have changed and Congress has taken steps to enable states to target long-term care services to certain populations in the State Plan through a special provision called the §1915(i) State Plan Option. In theory, this was intended to alleviate the administrative burden of waiver programs and still allow states to maintain some cost controls. Following is a discussion of the §1915(i) State Plan Option and the limitations of this new alternative.

## Federal Authority to Provide Home and Community-Based Services

### *Recent Changes in Federal Law*

New Freedom Initiative

In February 2001, President Bush announced the *New Freedom Initiative* as part of a nationwide effort to remove barriers to community living for seniors and individuals with disabilities. The initiative represents an important step in working to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, make choices about their daily lives and participate fully in community life. As discussed below, this initiative led to legislation that provided numerous federal grant opportunities, many of which Virginia successfully competed for and received.

Deficit Reduction Act of 2005 and the Affordable Care Act of 2010

Key changes to federal HCBS policies took place with the signing of the *Deficit Reduction Act (DRA) of 2005*. Resulting from the DRA, states have been provided the option to offer HCBS without a waiver and instead provide services through a §1915(i) State Plan Option. Few states took this option and many cited issues with this method of authority. Subsequently, the *Affordable Care Act of 2010* (ACA) addresses several concerns and barriers to existing home and community based options. Specifically, within the §1915(i) State Plan Option, significant changes were made.

Congress attempted to address the limitations of the §1915(i) State Plan Option as established under the DRA by amending its provisions through the Affordable Care Act of 2010. The main issues presented through the initial option and further addressed in the ACA were:

- Deficit Reduction Act: Through the State Plan Option as included in the DRA, states were not allowed to cover individuals with incomes greater than 150% of the Federal Poverty Level (FPL), while §1915(c) waivers allow for coverage up to 300% of Social Security Income (SSI) or $2,022 for a single individual.

    - Affordable Care Act: The ACA eliminates this restriction and allows states to now cover individuals up to 300% of SSI.
- Deficit Reduction Act: Unlike §1915(c) waivers, the DRA did not allow states to target services to specific populations under the State Plan Option. Thus, if a state believed a specific service was only necessary for a specific population, it must offer the service to everyone. This could be costly to states.
    - Affordable Care Act**:** ACA also eliminates this restriction with the goal of allowing more flexibility to states to target services for specific population needs.
- Deficit Reduction Act: The DRA only allowed services specified in a §1915(c) waiver to be offered through this option. Thus, true flexibility was not offered to states.
    - Affordable Care Act: ACA amended this provision, now allowing states to request exception to this rule.

## HCBS Provided through the New §1915(i) State Plan Option

As previously discussed, the *Deficit Reduction Act of 2007* and *Affordable Care Act of 2010* establish and amend §1915(i) of the *Social Security Act* to create the §1915(i) State Plan Option. This option is essentially a hybrid of the traditional Medicaid State Plan and Medicaid waivers.

At face value, the §1915(i) State Plan Option seems like a promising alternative to the complexities, limitations, and administrative burdens of DMAS' seven §1915(c) HCBS waivers; however, this new option still has requirements and restrictions that make it less attractive to states. Based on recent conversations with staff from the Centers for Medicare and Medicaid Services, to date, only five states have implemented or will soon implement this option and the majority of these states are using the §1915(i) State Plan Option to expand behavioral health services, not to provide supportive services to seniors or individuals with disabilities. The table below summarizes how states are currently using the §1915(i) State Plan Option.

**States using the §1915(i) State Plan Option**

| State | Use | Services Included |
|---|---|---|
| **Colorado** | Increase the use of self-direction | Personal Care<br>Homemaker Services<br>Home Health Aid<br>(all through self-direction) |
| **Iowa** | Target services for individuals with chronic behavioral health needs | Habilitation<br>Case Management |
| **Nevada** | Target services for individuals with chronic behavioral health needs | Habilitation<br>Case Management |
| **Washington** | Target services for the elderly and disabled | Adult Day Health Care |
| **Wisconsin** | Target services for individuals with chronic behavioral health needs | Habilitation<br>Case Management |

§1915(i) State Plan Option Compared to §1915(c) Waivers

As amended by the *Affordable Care Act*, the §1915(i) State Plan Option allows states to target home and community-based services to specific populations and provide services in varying amounts, duration, or scope to best meet the needs of specific populations (e.g., age, medical condition, disease, etc.). This is very similar to what a state is allowed to do through a §1915(c) waiver. Also, states can allow individuals with higher incomes to qualify for Medicaid in order to participate in a §1915(i) State Plan Option program. Like §1915(c) waivers, states can allow individuals with incomes up to 300% of the SSI amount to qualify for Medicaid based on their need for long-term care services. Further, the §1915(i) State Plan Option is not required to be budget neutral as compared to institutional care whereas §1915(c) waiver rules require budget neutrality. In these ways, moving a targeted group of services from a §1915(c) waiver to a §1915(i) State Plan Option would not cause a great deal of disruption.

In other ways, however, moving this group of services would have a significant impact on the Medicaid program. If the Department transitions a targeted group of services from a §1915(c) waiver to the §1915(i) State Plan Option, the Department could no longer require that individuals meet an institutional level of care in order to qualify for these services. States may establish needs-based criteria for services, but this criterion must be less stringent than what is required for institutional placement. Further, resulting from the *Affordable Care Act*, states can not limit the number of participants that receive §1915(i) State Plan Option services. Currently, the enrollment of several waiver programs is capped due to budget constraints.

The differences described above would expand access to HCBS for many individuals and hopefully delay the need for more extensive services; however, these requirements would have a significant fiscal impact. If waivers with waiting lists, such as the Mental Retardation/Intellectual Disabilities (MR/ID) or Individual and Family Developmental Disabilities (IFDDS) waivers, were moved to the §1915(i) State Plan Option, then the waiting lists would be eliminated. Based on a 2009 study by the Department, *Plan for the Elimination of Waiting Lists under Medicaid* (RD 216, 2009), this would result in a fiscal impact of $2.4 billion in general funds ($4.9 billion total funds) if this plan were phased in over the next decade. If the Department just transitioned the Elderly or Disabled with Consumer Direction waiver, expanded access to this program would result in an estimated fiscal impact of $93,153,355 in total funds ($46,576,678 in general funds) per year.[4]

Administration of §1915(i) State Plan Option

In addition, a significant incentive for eliminating waiver programs and providing those services through the State Plan is to decrease the administrative burden of maintaining authority for HCBS waivers. Unfortunately, the §1915(i) State Plan Option application process is similar to the application process for a waiver and the State Plan Option also requires a renewal by CMS every five years. CMS expects that this renewal process will be very similar to the rigorous waiver renewal process. CMS also expects that the quality oversight requirements will be

[4] Estimates as of June 30, 2010 and assuming a 15% utilization of the ABD population: $93,153,355 total is based on the combination of $1,149,861 in additional annual total fund expenditures for adult day health care and $92,003,495 in additional annual total fund expenditures for respite and personal care.

similar to those of the waivers. This would mean there would be a separate oversight process for this targeted group of services than for the rest of the State Plan for Medical Assistance. These requirements fail to eliminate or even lessen the administrative burden of maintaining the waiver programs. Advantages and disadvantages of moving waiver programs to the §1915(i) State Plan Option are summarized below:

Advantages to Providing HCBS Through the §1915(i) State Plan Option:

- **Expands eligibility/access for HCBS:** If Virginia chooses to move any or all of its §1915(c) HCBS waiver programs to the §1915(i) State Plan Option, per §1915(i) rules, DMAS would be able to target these services to individuals who need HCBS supports but who do not meet current institutional level of care requirements. Thus, home and community-based services would be available to more individuals in the Medicaid program.

- **Eliminates the cost neutrality requirement for HCBS:** If Virginia chooses to move any or all of its §1915(c) HCBS waiver programs to the §1915(i) State Plan Option, then it will no longer be required to prove that this group of services is cost neutral as compared to comparable institutional placements. This is a positive step towards eliminating the bias towards institutional care in the Commonwealth's long-term care system.

Disadvantages to Providing HCBS Through §1915(i) State Plan Option:

- **Does little to alleviate the administrative burden of waivers:** CMS has indicated that just like the HCBS waivers, each group of services provided under the §1915(i) State Plan Option is required to be renewed every five years. In addition, a quality strategy that is very similar to that of the HCBS waivers is also required. Providing quality programs and services is a priority of the Department, however, the quality reporting requirements are significant and complex, and they are not easily tailored to the ever-changing needs of Virginia's long-term care service recipients. These requirements also divert staff and resources to administrative tasks and away from program oversight.

- **Limited ability to control costs:** The §1915(i) State Plan Option does not allow states to place a limit on the number of individuals eligible to receive a certain group of services. Virginia currently has limits on enrollment in two HCBS waivers: the MR/ID and the IFDDS waivers. Also, Virginia would not be able to require that recipients of these services must qualify for institutional placement. This is the level of service need that is currently required to participate in a HCBS waiver. This would allow more people to be eligible for services. Individuals would receive services earlier which would hopefully prevent or delay further long-term care needs, but this would also significantly increase the amount of funding that is necessary for these services. The estimated fiscal impact of moving just one waiver – the EDCD waiver – to the §1915(i) State Plan Option is an additional $46,576,678 in general funds annually.

The DMAS analysis leads to the conclusion that while eliminating the obligation of obtaining HCBS wavier authority is extremely attractive, even with the amended federal requirements moving services to the §1915(i) State Plan Option, there are not sufficient benefits

to justify this transition. In addition, given the current state fiscal situation, the likelihood of securing the funding required to expand eligibility and service options appears low. Converting HCBS waiver programs to the §1915(i) State Plan Option does not appear to be a tenable option at this time.

## Conclusion

The goals of the various HCBS waivers in the Medicaid program are laudable and both the Governor and General Assembly have recognized these programs for the important services they provide. All involved agree that it is ideal to provide the opportunity for the elderly and individuals with disabilities to live in the community, as opposed to institutions, if the resources and supports are available to meet the unique and substantial needs of these individuals. This recognition and direction from policymakers is necessary for the continued movement towards a service delivery system focused on community living.

Over the past decade, Congress has taken steps towards providing states with the tools to optimally provide long-term care services to individuals in their homes and communities. While steps have been taken, it is still challenging for states to provide home and community-based services in the most person-centered, efficient, and cost effective way. Providing an easy to navigate, comprehensive community based long-term care delivery system is extraordinarily difficult. Unfortunately, the administrative limitations and requirements upheld by the federal government continue to pose yet another obstacle in truly eliminating the bias towards institutional care while providing optimal services.

Congress attempted to alleviate administrative obstacles for states through the §1915(i) State Plan Option, but its attempt fell short of its goal and without further flexibility from CMS on the implementation of §1915(i), CMS' planned implementation protocols will further perpetuate the administrative barriers.

Home and community-based long-term care services have a large fiscal impact on states; however, institutional placements are much more costly in terms of both financial resources and the withholding of a quality of life for individuals that is difficult to obtain when living in an institution. In many ways, Virginia is seeking to create a paradigm shift whereby the traditional institutional bias is being challenged by the offering and availability of home and community based services. From a fiscal standpoint, Virginia must ultimately commit to true rebalancing. If the Commonwealth is dedicated to providing long-term care in the home and community, funding must be redistributed from institutional towards community spending.

Unfortunately, without substantial financial investment from the state, neither the §1915(i) State Plan Option, as currently amended, nor adding services to the State Plan for Medical Assistance will enable the Commonwealth to resolve notable limitations in its provision of HCBS. As the momentum of interest for home and community-based long-term care services grows, new alternatives for administration of these services will inevitably be introduced. The Department will continue to stay abreast of changes and new alternatives for streamlined and cost-effective ways to administer these important services.

# APPENDIX A

**HOUSE JOINT RESOLUTION NO. 83**

Offered January 13, 2010

Prefiled January 12, 2010

*Directing the Joint Legislative Audit and Review Commission to study the costs and benefits of implementing the Home and Community-Based Services State Plan Option. Report.*

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Patrons-- Brink and Watts

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Referred to Committee on Rules

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WHEREAS, currently, Virginia offers home and community-based services to qualifying Medicaid-eligible elderly and disabled persons an Elderly and Disabled with Consumer Direction waiver; and

WHEREAS, in order to qualify for services through the Elderly and Disabled with Consumer Direction waiver, a person must meet the requirements for nursing home eligibility including needing assistance with four out of five activities of daily living; and

WHEREAS, the eligibility requirements for the Elderly and Disabled with Consumer Direction waiver prevent many individuals from accessing services offered through the waiver program when they are in need of services but do not require nursing home care; and

WHEREAS, the Home and Community-Based Services State Plan Option, authorized by the federal Deficit Reduction Act of 2005, offers states greater flexibility in determining eligibility for home and community-based services to Medicaid-eligible elderly and disabled persons and offers an opportunity to enable more elderly and disabled persons to access needed home and community-based services before they require institutionalized care; and

WHEREAS, upon enactment of the Home and Community-Based Services State Plan Option, Virginia could change eligibility requirements for services to offer services to more elderly and disabled persons in need of services, allowing elderly and disabled persons to receive home and community-based services such as case management, homemaker/health aid, personal care, adult day health, habilitation, and respite care services, preventing or delaying the need for institutionalized care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be directed to study the costs and benefits of implementing the Home and Community-Based Services State Plan Option.

In conducting its study, the Joint Legislative Audit and Review Commission shall determine the costs and benefits to the Commonwealth of implementing the Home and Community-Based Services State Plan Option.

Technical assistance shall be provided to the Joint Legislative Audit and Review Commission by the Department of Medical Assistance Services. All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2010, and for the second year by November 30, 2011, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Legislative Audit and Review Commission intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

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# APPENDIX B

## A Comparison of State Plan Option Personal Care Criteria and Nursing Facility Criteria in Six States

| State | Personal Care through State Plan Option | Nursing Facility |
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| **Alaska** | Recipient must need:<br>(1) Limited assistance in at least 1 ADL (person highly involved in activity; physical help in guided maneuvering of limbs or other non-weight bearing assistance 3+ times or limited assistance plus weight bearing 1 or 2 times in the past 7 days) AND<br>(2) Extensive assistance with at least 1 other ADL (weight bearing support needed 3+ times over last 7 days or full staff/caregiver performance during part (but not all) of last 7 days) | Recipient must be substantially limited in 3 of 7 ADLs |
| **Arkansas** | Recipient must require assistance for 1 or more physical dependency needs | Recipient must meet at least one of the following three criteria as determined by a licensed medical professional:<br>(1) The individual is unable to perform either of the following:<br>(a) At least 1 of the 3 ADLs of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or,<br>(b) At least 2 of the 3 ADLs of transferring/locomotion, eating or toileting without limited assistance from another person; or,<br>(2) The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose |

| State | Personal Care through State Plan Option | Nursing Facility |
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| | | serious health or safety hazards to himself or others; or,<br>(3) The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening. |
| **Nevada** | Recipient must meet at least 1 of the following criteria:<br>(a) has extensive impairments in 2 or more ADLs, and<br>(b) recipient has at least 1 of the following deficits:<br>(i) mobility deficits/impairments of an extensive nature which requires the use of an assistive device, and directly impact recipient's ability to safely perform household tasks or meal preparation independently;<br>(ii) cognitive deficits directly impacting recipient's ability to safely perform household tasks or meal preparation independently;<br>(iii) endurance deficits directly impacting recipient's ability to complete a task without experiencing substantial physical stressors; or<br>(iv) sensory deficits directly impacting recipient's ability to safely perform household tasks or meal preparation independently. | Recipient must have at least 3 functional deficits in the following areas:<br>(a) ADLs (mobility, transfers, locomotion, dressing, eating, feeding, hygiene, bathing, bowel and bladder);<br>(b) need for supervision;<br>(c) ability to perform IADLs (meal preparation and homemaking services related to personal care).<br>**AND** the recipient would require placement in a NF within 30 days if services or other supports were not available. |
| **Texas** | Recipient must have a functional limitation for at least 1 ADL. | Recipient must meet both (1) and (2):<br>(1) must meet 2 or more of the following:<br>(a) needs assistance with 1 or more ADLs;<br>(b) has functional decline in the past 90 days;<br>(c) has a history of a fall 2 or more times |

| State | Personal Care through State Plan Option | Nursing Facility |
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| | | in the past 180 days;<br>(d) has a neurological diagnosis of Alzheimer's, head trauma, multiple sclerosis, Parkinsonism, or dementia;<br>(e) has a history of NF placement within the last 5 years;<br>(f) has multiple episodes of urine incontinence daily; or<br>(g) goes out of one's residence one or fewer days a week; **AND**<br>(2) must meet the conditions described (a) and (b) below:<br>(a) must demonstrate a medical disorder or disease or both, with a related impairment that:<br>(i) limits ability to recognize problems, changes in condition, and the need for or side effects of prescribed medications;<br>(ii) is of sufficient seriousness that needs exceed the routine care which may be given by an untrained person; and<br>(iii) requires nurses' supervision, assessment, planning, and intervention that are available only in an institution;<br>(b) individual must require medical/nursing services that:<br>(i) are ordered by and remain under the supervision of a MD;<br>(ii) are dependent upon the individual's documented medical, physical, and/or functional disorders, conditions, or impairments;<br>(iii) require the skills of RN or licensed vocational nurses;<br>(iv) are provided either directly by or under the supervision of licensed nurses in an institutional setting; and |

| State | Personal Care through State Plan Option | Nursing Facility |
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| | | (v) are required on a regular basis. |
| **Virginia** | N/A | Recipients must meet both functional capacity requirements and have a medical condition that requires ongoing medical or nursing management. An exception may be made when the individual does not meet the functional capacity requirement but does have a health condition that requires the daily direct services of a licensed nurse that cannot be managed on an outpatient basis.<br>(1) Recipient must meet one of the following functional capacity requirements:<br>(a) rated dependent in 2 to 4 ADLs, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and semi-dependent in Joint Motion or dependent in Medication Administration; or<br>(b) rated dependent in 5 to 7 ADLs, and also rated dependent in Mobility; or<br>(c) rated semi-dependent in 2 to 7 ADLs, and also rated dependent in Mobility and Behavior Pattern and Orientation; **AND**<br>(2) Recipient must meet one of the following medical or nursing needs:<br>(a) individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals; or<br>(b) due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists; or |

| State | Personal Care through State Plan Option | Nursing Facility |
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| | | (c) the individual requires at least one ongoing medical/nursing service |
| **Washington** | Recipient must be functionally eligible which means one of the following applies:<br>(i) recipient has an unmet or partially met need with at least 3 ADLs; **OR**<br>(ii) recipient has an unmet or partially met need or the activity did not occur (because the recipient was unable or no provider was available) with at least 1 or more ADLs | Recipient must meet one of the following:<br>(1) requires care provided by or under the supervision of a RN or a LPN on a daily basis; or<br>(2) has an unmet or partially met need with at least 3 ADLs; or<br>(3) has an unmet or partially met need with at least 2 ADLs; or<br>(4) has a cognitive impairment and requires supervision due to 1 or more of the following: disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least 1 or more ADLs.<br>If the need for assistance in any activities listed in subsections below did not occur because the recipient was unable or no provider was available to assist the recipient, this will be counted for the purpose in determining functional eligibility |