COMMONWEALTH of VIRGINIA

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January 31, 2012

MEMORANDUM

TO: The Honorable Robert F. McDonnell
Governor of Virginia

The Honorable Lacey E. Putney, Chair
House Appropriations Committee

The Honorable Charles J. Colgan, Chair
Senate Finance Committee

FROM: Cynthia B. Jones

SUBJECT: Review of Potential Waiver Changes and Associated Costs Related to Improving the Intellectual Disability (ID), Day Support (DS), and Individual and Family Developmental Disabilities Support (DD) Waivers

This report responds to Section BBBBB of the *2011 Acts of Assembly* directing that the Departments of Medical Assistance Services (DMAS) and Behavioral Health and Developmental Services (DBHDS) review of the current Intellectual Disability (ID), Day Support (DS) and Individual and Family Developmental Disabilities Supports (DD) Waivers to identify any improvements and report on the proposed waiver changes and associated costs to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2011 (Appendix A). Because of on-going discussions with the Department of Justice concerning the February 2011 finding letter, report completion was delayed.

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

Review of
Potential Waiver Changes and Associated Costs Related to Improving the Intellectual Disability (ID), Day Support (DS), and Individual and Family Developmental Disabilities Support (DD) Waivers

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL SERVICES

January 31, 2012

Notice:

This report is based on research and analysis conducted prior to settlement with the Department of Justice (DOJ) regarding a February 2011 "Findings Letter" (the "DOJ settlement"). To the extent components herein are inconsistent with the DOJ settlement entered on January 26, 2012, that is an artifact of the timing of the analysis for this report and finalization of the settlement.

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Executive Summary

Section BBBBB of the *2011 Acts of Assembly* directs the Departments of Medical Assistance Services (DMAS) and Behavioral Health and Developmental Services (DBHDS) to review of the current Intellectual Disability (ID), Day Support (DS) and Individual and Family Developmental Disabilities Supports (DD) Waivers to identify any improvements and report on the proposed waiver changes and associated costs. The language further requires that the Departments consult with appropriate stakeholders and national experts in order to increase the efficiency and cost effectiveness of the waivers, enable more individuals to be served, strengthen the delivery of person-centered supports, enable individuals with high medical needs and/or high behavioral support needs to remain in the community setting of their choice and provide viable community alternatives to institutional placement. This document is intended to meet the requirement of such a review.

Virginia's home and community-based services (HCBS) waivers are funded by the Medicaid program to enable individuals to receive long-term care services in a less restrictive community setting in a more cost effective manner than if the individual had been placed in an institution. Section 1915 (c) of the Social Security Act allows states, with the approval of the Centers for Medicare and Medicaid Services (CMS), to "waive" certain federal requirements in the provision of Medicaid services. The Commonwealth developed the ID, DS and DD Waivers to "target" services to individuals with developmental disabilities (DD), including intellectual disability (ID). The ID Waiver, serving individuals with intellectual disability, was created in 1991; the DD Waiver, serving individuals with a developmental disability over the age of six, was created in 2000; and the DS Waiver was created in 2005 to serve individuals with intellectual disability who were on the waiting list for the ID Waiver. The three waivers differ in size based on past decisions of state lawmakers; the ID, DS and DD Waivers are currently authorized to serve 8,937, 300 and 803 individuals, respectively (as of July 2011). Waiver "slots" are approved and funded by the Virginia General Assembly and subsequently approved by CMS to identify the number of individuals to be served and to draw down the federal matching funds. The ID and the DD Waivers have significant waiting lists, 5,825 and 1,127 respectively.

Each waiver was originally designed to meet the specific needs of the individuals with ID *or* DD; however, as developmental disabilities is an umbrella term which includes individuals with intellectual disability, many states have reviewed the administration and array of waiver services available to individuals with DD, including ID, and designed a single comprehensive waiver covering both populations. Input from individuals with DD/ID and their families support an expanded array of available services and housing options. To this end, this report addresses these areas and frames improvements for the ID, DS and DD Waivers in short and long-term strategies.

Short-term enhancements include options to adjust the Medicaid provider rates to increase availability of smaller residential settings (group homes of four beds or less and

in-home residential supports); to enhance services to individuals with high medical and/or behavioral needs by creating an exceptional rate for individual receiving residential support services; and, to increase the number of services available in the DS Waiver. As any change to a HCBS waiver requires prior approval of CMS, amending the existing waivers is a less rigorous process than making major structural changes to a waiver (i.e. changing the target population, modifying the case management structure, adjusting the waiting list process, etc). Long-term enhancements are more appropriately handled through the waiver renewal process that could include the major structural changes mentioned previously, as well as realignment of the state responsibilities related to administrative oversight and financial accountability of the ID, DS and DD Waivers.

Introduction

This report responds to Section BBBBB of the *2011 Acts of Assembly* directing that the Departments of Medical Assistance Services (DMAS) and Behavioral Health and Developmental Services (DBHDS) review of the current Intellectual Disability (ID), Day Support (DS) and Individual and Family Developmental Disabilities Supports (DD) Waivers to identify any improvements and report on the proposed waiver changes and associated costs to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2011 (Appendix A). Because of on-going discussions with the Department of Justice concerning the February 2011 finding letter, report completion was delayed.

From 2006 forward, various studies and reports identified issues related to enhancing services to individuals with developmental disabilities (DD), including intellectual disability (ID). The report *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation*[1]*, and Substance Abuse Services System* provided the framework for transforming Virginia's publically funded system serving individuals with behavioral health needs and individuals with ID. In 2009, JLARC noted in *Assessment of Services for Virginians with Autism Spectrum Disorders* (House Document No.8) that "while Virginia and many other states have focused historically on intellectual disability, there has been a national shift toward overseeing all developmental disabilities through one entity." Effective July 1, 2009 and reflected in its name change, DBHDS was designated the state agency responsible for overseeing the delivery of services to individuals with all types of developmental disabilities.

While DBHDS' responsibilities have been expanded to include individuals with DD, the administration and service delivery through Virginia's ID, DS and DD Waivers have not changed significantly. DMAS is the single state agency identified by Statute as responsible for the overall administration of the Medicaid program in Virginia. DMAS, however, has delegated to DBHDS certain authorities related to the Medicaid program, including some related to the ID and DS Waivers. These authorities are specified in an interagency agreement between the two agencies to assure that Virginia will carry out all federal and state requirements related to the Medicaid program.

This report examines many areas identified in previous reports including rate structure for Medicaid waiver services, available services offered through the ID, DS and DD Waivers, individual and family preferences in services, and other states' efforts to further develop community based services for individuals with DD. DMAS and DBHDS have framed this report to identify options to improve the ID, DS and DD Waivers over the short and long-term.

- Short-term modifications can be made over the next year or two to assist individuals to transition from state training centers into communities and to

[1] The current preferred language is Intellectual Disability (ID)

support individuals in the most appropriate integrated setting to meet their needs. These short-term enhancements can be accomplished within the current waiver structure if funding is appropriated by the General Assembly and the changes are approved by CMS.

- Long-term changes, such as combining populations served through a waiver, adjusting eligibility requirements or streamlining service delivery should be examined and planned carefully to ensure that services are not disrupted to individuals currently supported by waiver programs and that the numbers of individual waiting to receive waiver services are reduced as a result of actions. These longer-term improvements would require three to five years and could be done through the waiver renewal process scheduled for 2013 and 2014.

This report reflects the two departments' proposed options for both short-term and long-term changes designed to conform to existing federal time frames for waiver changes and renewals as well as Virginia's legislative and budget processes.

Background

Virginia's state-funded community-based system of services and supports for individuals with intellectual disability (ID) commenced on a statewide basis with the creation of the Community Services Board system in 1968. Over a period of several years following their establishment in §37.2-500 of the *Code of Virginia*, 40 separate boards were created to develop and oversee community services for individuals with intellectual disability, and mental health disorders. Later, substance abuse was added to their responsibilities at the community level.

For the first twenty years after the formation of the CSB system, funding for services to serve individuals with ID, mental health disorders and substance abuse was from a combination of state General Funds and local government matching funds. In 1991 Virginia developed a home and community-based service waiver for individuals up to age six (6) who are at developmental risk and individuals age (6) and older with ID that allowed for federal matching funds through Medicaid. Virginia's decision to enter this program, along with every other state in the nation, resulted in the doubling of the available funding for resources to serve qualifying individuals in community settings. In order to provide case management to individuals with ID, Virginia included targeted case management as a State Plan Option to serve qualifying individuals with ID, regardless of whether or not the individual qualified for waiver services.

The development of Virginia's community system to serve individuals with ID paralleled an important federal occurrence, the passage of *Title 42 – Chapter 136: Equal Opportunity for Individuals with Disabilities,* known as the Americans with Disabilities Act ("ADA") in 1990. This federal law provides for comprehensive civil rights protections for individuals with disabilities in the areas of employment, public accommodations, State and local government services, and telecommunication. One year later in 1991, Virginia received federal approval for the first Medicaid Waiver to serve

qualifying individuals at developmental risk or with an intellectual disability in home and community settings rather than in institutions – now called the Intellectual Disability (ID) Waiver.

Beginning July 1, 2000, Virginia received federal approval to implement the Individual and Family Developmental Disabilities Services (DD) Waiver, which expanded home and community based services to individuals age six an older with developmental disabilities who did not have an intellectual disability diagnosis. At the time the DD Waiver was developed, families and individuals with developmental disabilities, advocates and stakeholders recommended that the waiver should not include congregate residential as a service option. It was believed that the creation of a congregate residential option would support more restrictive settings than appropriate for individuals, and there was strong consensus that waiver funds be used on other community supports.

Both the ID and DD Waivers developed significant waiting lists despite the effort to provide community services and supports. The Day Support (DS) Waiver was created in 2005 in an effort to provide some support to families with individuals on the ID Waiver waiting list.

This section of the report provides an overview on the administrative authority of the Virginia Medicaid program relative to 1915 (c) Home and Community-Based Services (HCBS) Waivers and an overview of the Intellectual Disability, Day Support and Individual and Family Developmental Disabilities Waivers in Virginia.

Waiver Authority

Section 1915 (c) of the Social Security Act allows states, with the approval of the Centers for Medicare and Medicaid Services (CMS), to "waive" certain requirements in the provision of Medicaid services. The Commonwealth developed the ID, DS and DD Waivers to "target" services to individuals with developmental disabilities, including intellectual disability.

The §1915(c) waiver programs enable eligible Virginians to receive long-term care services in a less restrictive community setting in a more cost effective manner than if the individual had been placed in an institution. To participate, otherwise eligible individuals must be assessed as having the same level of need as someone who qualifies for institutional placement, such as an intermediate care facility (ICF) for persons with intellectual disabilities, hospital, or nursing facility **and** be at risk of such facility placement.

As with all §1915(c) waiver programs, states must meet federal criteria in order to receive approval for administration of a waiver program. Waivers are approved by CMS initially for three years, and must be renewed every five years through a very extensive process. Maintaining authority for the §1915(c) waiver programs includes the need to demonstrate cost-effectiveness and the need to exhibit safeguards to ensure the health,

safety and welfare of individuals and evidence to assure CMS that the state has appropriate administrative and financial accountability for each waiver.

If a state wishes to change one of its waiver programs between renewal periods, it must re-open its waiver application with CMS to submit the changes. This process is somewhat complex as CMS does not just evaluate the requested change; CMS re-evaluates the entire application. If CMS or Congress has recently changed requirements, this can pose unanticipated consequences for the state. Unlike the waiver amendment process, the waiver renewal process affords states the opportunity to review all aspects of a waiver and to make significant changes, or to replace an existing waiver with a new waiver.

Overview of the Current ID, DS and DD Waivers

Although the ID, DS and DD Waivers were created at different times to meet a variety of needs, all three serve one common purpose, *to enable individuals who are eligible for institutional care to receive services in their home and community at a lesser cost to the Commonwealth and in a less restrictive setting than institutional placement.* Table 1 below shows a comparison of the populations served, approved slots and waiting list for each waiver:

Table 1: Description of Virginia's Waiver Programs for Individuals with Developmental Disabilities (July 1, 2011 data)

Waiver	Population Served	Approved Slots[2]	Waiting List[3]
ID	Individuals under the age of 6 who are at developmental risk *and* individuals with an ID diagnosis. Must meet the Level of Functioning Criteria.	8,937	5,825
DS	Individuals with an ID diagnosis. Must meet the Level of Functioning Criteria.	300	Uses ID Waiver waiting list above
DD	Individuals above the age of 6 years who have a developmental disability, but not ID. Must meet the Level of	803	1,127

[2] CMS Approved Waivers: ID (VA0372.R02.04), DS (VA0430.R01.00) and IFDDS (#0358.R02.02). The numbers of slots above include Money Follows the Person (MFP) Program slots in the ID and IFDDS Waivers.

[3] DMAS Division of Long-Term Care Weekly Management Report July 1, 2011.

	Functioning Criteria.		

The ID and the DD Waivers offer an **identical array of services** to individuals with ID/DD residing in the community, except that a congregate residential option is available only in the ID Waiver and family/caregiver training is available only in the DD Waiver. The limited number of services available through the DS Waiver is consistent with the original purpose of that waiver which was to offer individuals and families with some "day support" outside of the home. Table 2 below shows the services available through the ID, DS and DD Waivers:

Table 2: Listing of Services Available through Virginia's Waivers Targeting Individuals with Developmental Disabilities (July 1, 2011 data)

DS Waiver	***DD Waiver***	***ID Waiver***
	Adult Companion Services (agency directed)	Adult Companion Care (agency and consumer directed)
	Assistive Technology	Assistive Technology
		Congregate Residential
	Crisis Stabilization	Crisis Stabilization
	Crisis Supervision	Crisis Supervision
Day Support (regular and intensive)	Day Support (regular and intensive)	Day Support (regular and intensive)
	Environmental Modifications	Environmental Modifications
	Family/Caregiver Training	
	In-Home Residential	In-Home Residential
	Personal Care (agency and consumer directed)	Personal Care (agency and consumer directed)
	Personal Emergency Response System (PERS)	Personal Emergency Response System (PERS)
Prevocational Services (regular and intensive)	Prevocational Services	Prevocational Services (regular and intensive)
	Respite (agency and consumer directed)	Respite (agency and consumer directed)
	Services Facilitation	Services Facilitation
	Skilled Nursing	Skilled Nursing
Supported Employment (individual and group models)	Supported Employment (individual and group models)	Supported Employment (individual and group models)
	Therapeutic Consultation	Therapeutic Consultation
	Transition Services	Transition Services

While the array of waiver services is similar, there are significant administrative and design differences between the ID/DS and DD waivers:

- *Case management process* - By Statute, CSBs provide case management to individuals with ID; private case managers provide case management to individuals on the DD waiver or those who are Medicaid eligible and who on the waiting list for the DD waiver;

- *Wait lists management* – When slots become available, the criteria for addressing the ID Waiver waitlist is urgency of need, while the criteria for the DS and DD Waivers is first come, first serve. DBHDS manages the ID and DS Waivers waitlist and DMAS manages the DD waiver wait list;

- *Authorization for services* - DBHDS prior authorizes services for the ID and DS Waivers; DMAS prior authorizes services for the DD Waiver primarily through a private contractor;

- *Approved slots* – ID Waiver has approximately ten times the number of approved waiver slots (which determine the maximum number of individuals that can be served) than the DD Waiver; in addition to service utilization, the number of slots drives the total cost of the waivers to the Commonwealth.

Additional details about the ID, DS and DD Waivers are included in Fact Sheets. (See Appendixes B, C, and D, respectively.)

Potential Short-Term Waiver Modifications

This section of the report discusses approaches that would allow Virginia to enhance the ID, DS and DD Waivers in the short-term through the waiver amendment process. Consideration has been given to changes that can be made within the existing CMS approved home and community-based waivers and within the state's fiscal timeframes. These changes address areas identified by Virginia's stakeholders (see Appendix E) and previous reports to the General Assembly regarding the availability of services and the adequacy of payment rates to serve individuals with the most complex needs. In addition, some of the short-term options may serve as incentives for providers to operate smaller residential homes with four beds or less. An increase in the availability of smaller residential homes may also address concerns about the underutilization of the Money Follows the Person (MFP) Program which prohibits placement of MFP participants in residential home settings of more than four beds.

Residential Service Options

For purposes of responding to the request in Item 297.BBBBB of the Appropriation Act, DMAS, with the assistance of DBHDS, undertook a review of rates for residential services available to individuals in the ID and DD waivers. The intent of

the review is to provide viable community alternatives to institutional placement and to provide individuals an effective choice of residential setting.

Medicaid reimburses for supportive services in personal homes, group homes and host family homes (referred to as sponsored residential). Medicaid does not reimburse for room and board. Most individuals in the waivers use income from Supplemental Security Income (SSI) to cover the costs of room and board, regardless of the residential setting.

In order to provide viable community alternatives to institutional placement and a choice of residential setting, it is necessary to appropriately reimburse for various residential settings. There are differences in cost to furnish supportive services in different residential settings. If rates do not reflect those cost differences, providers will likely make available those services that are best reimbursed relative to their cost, and individuals may not have the choice of all services.

There is very little hard evidence about the adequacy of current rates. In general, most individuals receive close to the number of authorized hours of service (which are based on documented individual needs), with the possible exception of services in the family home. Anecdotally, however, the hourly wages that providers pay to employees may not be sufficient to hire and retain the best qualified staff. For example, a provider may hire two part-time employees rather than one full-time employee in order to avoid the cost of benefits.

One possible indirect indicator of the inadequacy of current rates is that only 28% of the licensed beds are in group homes of four beds or less. Economies of scale may make it more financially viable for the larger group home under the current rate structure. As a result, it may be desirable to have a rate structure that better supports smaller group homes, particularly with the Commonwealth's articulated desire to serve individuals in the least restrictive environment as appropriate. Smaller group homes are more desirable for the increased attention provided to the residents and the enhanced ability of smaller groups of individuals to best integrate into their communities.

Finally, the current hourly rates, regardless of authorized hours, are generally deemed insufficient for individuals with very high medical and/or behavioral needs who are more challenging to serve in the community. Adequately supporting these individuals is particularly critical to achieve the goal of moving individuals from state training centers to the community, which has historically proven difficult. An enhanced residential rate for those individuals is one option under consideration.

The rate-related proposals in this report can be implemented in a short timeframe. More comprehensive changes to the waiver structure and the rates to support that structure (daily rates rather than hourly rates, for example) may be desirable in the long-term. These short-term rate changes, however, would not preclude making more substantial structural and rate changes later.

The rate section of this report includes a background subsection on rate history, utilization and residential settings. The next two subsections discuss possible changes to the congregate residential rate, which currently supports individuals in group homes and sponsored residential homes, and the in-home residential rate, which supports individuals who live on their own or with family or friends. The last rate subsection discusses enhanced rates for individuals with very high needs. The concluding subsection describes the fiscal impact associated with the options.

Background

Virginia's system for providing residential support services through the ID and DD waivers reimburses three settings: group homes, sponsored homes and in-home residential. Currently, Medicaid pays a congregate residential support hourly rate for ID waiver individuals in group homes and sponsored homes. A separate in-home residential support hourly rate is paid for ID and DD waiver individuals in their own home.

As of May 2011, DBHDS reports 7,753 individuals in the ID Waiver; DMAS reports 742 individuals in the DD Waiver. The Table 3 shows the number of individuals authorized for residential support services by setting and waiver.

Table 3: Number of Individuals in ID and DD Waivers Authorized for Residential Support Services

Residential Support Services	Individuals enrolled in the ID Waiver	Individuals enrolled in the DD Waiver
Congregate Residential (Group Home)	3,583	N/A
Congregate Residential (Sponsored Residential)	820	N/A
In-home Residential	1,128	136
No Authorization for Residential Support Services	2,222	606

The initial waiver rates were established using informal surveys of CSBs to determine the costs of services at the time the ID waiver was created. Residential services were originally designed as supplemental services to provide habilitation to individuals according to their needs. One rate for all residential services was used until 2000 when a separate rate was established for in-home residential services. Sponsored residential has always been paid the same congregate residential rate as group homes.

Rates for residential services were unchanged from 1991, when the ID waiver started, until 2000. The same rate of $12.50 was paid for all residential services in all parts of the state. A separate rate for in-home residential was established in 2000 that was 41% higher than the congregate residential rate. Between 1999 and 2007, congregate residential rates increased 18.4% while the in-home residential rate increased 10.3%. In FY08, a 15% rate differential was implemented across all services for

Northern Virginia. Since 2008, there have been both rate increases and decreases. The current FY12 congregate residential rates are 1% higher than the FY08 rates and the in-home residential rates are 1% lower than the FY08 rates. In-home residential rates are currently 31% higher than congregate residential rates. Table 4 shows a history of Medicaid hourly rates for congregate residential services and in-home residential services.

Table 4: History of Medicaid Hourly Rates for Congregate Residential Services and In-Home Residential Services

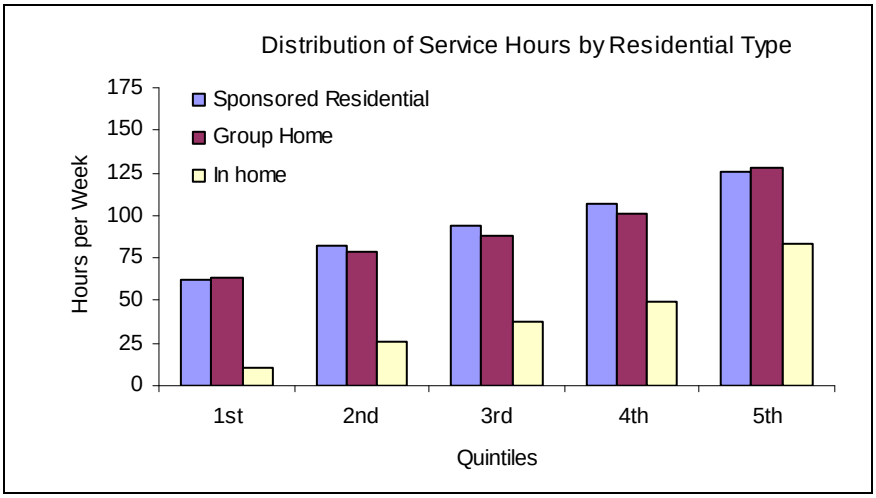
History of Medicaid Hourly Rates for Congregate Residential Services			History of Medicaid Hourly Rates for In-Home Residential Services		
SFY	Northern Virginia	Rest of State	SFY	Northern Virginia	Rest of State
1992	$12.50		1992	$12.50	
2000	$12.81		2000	$18.00	
2005	$12.85		2005	$18.06	
2006	$13.45		2006	$18.90	
2007	$14.80		2007	$19.85	
2008	$17.02	$14.80	2008	$22.82	$19.85
2009	$17.63	$15.33	2009	$22.82	$19.85
2010	$17.36	$15.10	2010	$22.82	$19.85
2011*	$16.49	$14.35	2011*	$21.68	$18.86
2011	$17.36	$15.10	2011	$22.82	$19.85
2012	$17.19	$14.95	2012	$22.59	$19.65

*In SFY 2011 rates were reduced three percent and subsequently restored on Oct. 1 when federal stimulus funds were extended.

Residential services are authorized in hourly increments according to the individual's specific needs. In order to determine the necessary level of care, providers submit individual plans of care for service authorization. The plan of care ensures the appropriate amount of hours is available to address individual levels of need. Hourly reimbursement provides flexibility within the waivers to allow for a range of individual needs.

According to DBHDS, individuals in the ID waiver with in-home residential services are approved for an average of 41 hours per week. Individuals residing in sponsored residential and group homes receive more than twice the number of hours as those receiving in-home residential services, 94 hours and 92 hours respectively. This is largely due to the fact that those in group homes and sponsored residential homes receive their primary care from paid staff, while those getting in-home supports generally have an unpaid primary caregiver. The graph (Figure 1) further highlights the distribution of authorized hours by quintile for the three residential types. Each quintile represents 20% of the population ranked from low (the first quintile) to high (the fifth quintile) in number

Figure 1



of authorized hours of each service. The bar chart indicates the average number of hours of authorized service for each quintile. While claims data shows billed hours per week for congregate residential is very close to authorized hours, billed hours per week for in-home residential is only 36 hours, only 88 percent of the authorized hours. Weekly and annual reimbursement is based on the rate multiplied by the hours billed. Weekly and annual reimbursement per individual is calculated in Appendix F for each service, region and hours of service by quintile.

Medicaid does not allow reimbursement for room and board. Most individuals enrolled in the ID and DD Waivers are eligible for Supplemental Security Income (SSI) to cover basic living expenses, including room and board. Individuals in a group home or sponsored home use a portion of their SSI benefit to pay for the cost of room and board. Medicaid allows $40 per month for individuals in nursing facilities as a personal needs allowance. Assuming that $40 is excluded for personal expenses, an individual relying solely on SSI would pay $634 monthly towards room and board in a group home or sponsored home.

Reimbursement for Group Homes

In Virginia, group homes are licensed by the DBHDS to provide 24-hour supports and supervision in a community-based, home-like dwelling. The size of group homes is increasingly becoming an issue. According to DBHDS, there are 1,029 group homes in Virginia with 5,419 licensed beds. Twenty-eight percent of beds are in facilities with four beds or less, 42 percent are in facilities with five to six beds and 29 percent are in facilities with seven or more beds. Of Virginia's licensed group homes for individuals with ID, more than half of group homes are licensed for more than 4 beds; there are 38 group homes licensed for 10 beds or more. Table 5 compares the group home size, number of facilities and number of beds.

Table 5: Virginia's Group Homes by Bed Size

Group Home Bed Size	Number of Facilities	Number of Beds
4 or less	430	1,530
5	191	955
6	223	1,338
7	52	364
8	90	720
9+	43	512
Total	1,029	5,419

Occupancy is dynamic; it can change on a daily basis. It would appear that the group home occupancy rate is currently 66 percent (3,583 individuals in group homes divided by 5,419 available beds). While the distribution of empty beds is not entirely known, the Virginia Network of Private Providers states that 40 percent of sites which qualify for Money Follows Person (MFP) referrals (i.e., group homes of four beds or less and sponsored residential) have vacancies. The MFP Program offers temporary enhanced federal reimbursement for individuals exiting an institution and enrolling into one of Virginia's HCBS Waivers. It would benefit the Commonwealth to maximize the use of smaller group homes (four or fewer unrelated individuals) required for the enhanced federal reimbursement available through the MFP Program.

In order to expand the use of smaller group homes across the Commonwealth, DMAS and DBHDS developed short-term rate options for group homes based on national trends and prior studies on the provision of services to individuals with developmental disabilities. In addition, the 2007 *Report of the Study of the Mental Retardation System in Virginia* to the Governor by the DBHDS cited increasing the rates for all models of residential support of four beds or less in the ID waiver. The 2007 report recommended "a 25 percent rate increase for MR Waiver models of residential support of four beds or less (except 'sponsored residential' homes) to make smaller settings financially feasible and promote the Money Follows the Person initiative." An earlier DBHDS study on the *Cost and Feasibility of Alternatives to the State's Five MR Training Centers* (2005) made a recommendation for a ten percent increase for the same models.

The short-term rate options proposed below are based on the following assumptions associated with expected provider behavior, economic feasibility and the existing occupancy rate for group home residential settings.

Economic Feasibility

Congregate residential hourly rates cannot be evaluated by developing a cost based on staff cost per hour. First, congregate rates are predicated on staff providing services to more than one individual and the ratio of staff per waiver individual may vary

throughout the day based on the needs of the individuals in the home. Second, the provider's financial goal is to provide all the services required in a group home (room and board, general supervision and Medicaid waiver-covered support services) while covering all of the costs with revenue from all available resources (primarily the SSI income of the individual and Medicaid reimbursement) in order to meet the needs of the individuals residing in the home. There are several annual Medicaid revenue projections for different group home configurations (based on size and levels of need) in the table below and Appendix G. In each case, the provider, at a minimum, receives an additional $7,608 per person for room and board.

Mathematically, increasing the congregate residential rate by 25 percent for group homes of four beds or less produces the same amount of revenue as five-bed group homes, assuming the group homes are fully occupied (See Table 6.) The fact that the annual reimbursement is the same suggests that providers will have an incentive to operate as four-bed or less group home and qualify for the increased rate and the same revenue. The estimate assumes that providers that continue to operate group homes with more than four beds will receive the current congregate residential rate.

Table 6: Congregate Residential Rate Scenarios

Group Home	Current Rest of State (ROS) Rate	Current ROS Annual Reimbursement	ROS Rate Increased 25 Percent	Increased ROS Annual Reimbursement	Difference
4 individuals with average hours	$ 14.95	$ 285,989.91	$ 18.69	**$ 357,487.39**	71,497.48
5 individuals with average hours	$ 14.95	$ 357,487.39	$ 14.95	**$ 357,487.39**	0.00
6 individuals with average hours	$ 14.95	$ 428,984.87	$ 14.95	$ 428,984.87	0.00

ROS - Rest of State

Provider Behavior and Occupancy Rate

A 25-percent increase to congregate residential services provided by licensed group homes is expected to produce changes in provider behavior. Based on the economic feasibility assumption that the current reimbursement for fully-occupied five-bed group homes would be the same as the increased reimbursement for a fully-occupied four-bed group home, the cost estimate reflects the expectation that 100 percent of five-bed group homes will convert to four beds or less. Group homes licensed for six beds may also convert to four-bed group homes, if the residential providers can reduce costs by 17 percent to match the reduction in revenue resulting from converting to fully-occupied four-bed group homes.

Considering the occupancy rate of 66 percent across all group home providers, many six-bed group homes may be de facto four or five-bed group homes. As a result, the cost estimate assumes that 50 percent of group homes with six beds or more will convert to four-bed group homes. The cost estimate also assumes that individuals on the waiver will utilize group homes with four beds or less.

Congregate Residential Rate Options

This report models the impact of rate options associated with the recommended changes for each residential service. Based on the recommendations of the 2007 DBHDS report and expected provider behavior, a 25-percent rate increase may be warranted for certain congregate residential services. Option 1A on Table 7 summarizes the rates for a 25-percent increase to congregate residential rates for group homes of four beds or less.

Taking into consideration the existing occupancy rate of 66 percent, it may not be necessary to increase the rates by 25 percent. A previous study by JLARC in 2006 noted the continued increase of providers entering the congregate residential market, indicating a financial incentive to do so may already exist under the current rate structure. Therefore, a lesser increase may be a sufficient incentive for group homes to convert or continue to operate with four or fewer individuals. A ten percent rate increase option applied to qualified group homes (licensed for four beds or less) is provided as Option 1B on Table 7.

Table 7: Congregate Residential Rate Options

Congregate Residential Rate	ROS	NOVA
Current	$14.95	$17.19
Option 1A - Increase Congregate Residential Rate for Group Homes with 4 Beds or Less by 25 Percent	**$18.69**	**$21.49**
Option 1B - Increase Congregate Residential Rate for Group Homes with 4 Beds or Less by 10 Percent	**$16.45**	**$18.91**

ROS - Rest of State
NOVA – Northern Virginia

Operational Impact

Implementing the rate differentials will require operational changes including, but not limited to, billing changes and provider enrollment changes. Only individuals living in group homes that are licensed for four beds or less will qualify for the higher congregate residential rate. DMAS will identify a modifier for providers to use on claims for congregate residential services in group homes of four beds or less so that DMAS can pay the higher congregate residential rate. Eventually, DMAS would like to modify provider enrollment policies and procedures to link individual group home sites to the Medicaid provider billing number, the National Provider Identifier (NPI). The main office may enroll under a group NPI and identify the individual site. Individual sites may also enroll and bill using the NPI assigned for each individual site. Claims can then be linked to specific group homes and matched to licensing records.

Reimbursement for Sponsored Residential

Currently, rates for sponsored residential services and congregate residential services are the same, although there is strong evidence that the sponsored residential model is less expensive than the group home model. In the sponsored residential model, the provider recruits families to serve one or two individuals in their home. The provider furnishes training, supervision and some support services. Based on current reimbursement rates and average hours per week of 94, annual Medicaid reimbursement in the Rest of State is $73,454, plus room and board of $7,608, for one individual and $146,908, plus room and board of $7,608, for two individuals. Assuming that the provider takes 20% of the Medicaid reimbursement for training, supervision and supports, the family's income is $66,491 for one individual and $132,982 for two individuals. The family does incur expenses related to services to the waiver individuals, but much of the family cost is a fixed cost associated with the family's expenses.

It can be argued that reimbursement for sponsored residential should be less than reimbursement for four-bed group homes. However, the intention is not to discourage this model of residential support. The model fits the goals of less-restrictive person-centered services; nevertheless, evidence from other states and evaluation of the costs of providing the service suggest that the rate should be lower than the congregate residential rate. A recent rate study conducted by Burns and Associates for the state of Georgia recommended that rates for sponsored homes be 28 percent lower than rates for group homes of four beds or less.

The options modeled in this report are a sponsored residential rate 25 percent lower than the congregate residential rate for four beds or less. If there is a 25-percent increase to congregate residential rates for four beds or less, then the rate for sponsored residential will be 6.25 percent lower than the current rate. If there is a 10-percent increase to congregate residential rates for four beds or less, then the rate for sponsored residential will be 17.5 percent lower than the current rate.

Even though a lower rate for sponsored residential is recommended, providers have grown accustomed to this level of reimbursement. Rather than reduce the rate, one additional option is not to increase sponsored residential rates until the differential between sponsored residential rates and congregated residential rates for four beds or less would exceed 25 percent. Of course, there would be no savings associated with this option.

Sponsored Residential Rate Options

Option 2A and Option 2B on Table 8 represent the rate options for sponsored residential. There are two options based on either a 25-percent or 10-percent increase to congregate residential rates for four beds or less, with sponsored residential 25 percent or 10 percent lower, respectively.

Table 8: Sponsored Residential Rate Options

Sponsored Residential Rate	ROS	NOVA
Current	14.95	17.19
Options Based on Sponsored Residential Rates 25 Percent Lower than Congregate Residential Rates for Group Homes of Four Beds or Less		
Option 2A - Congregate Residential Rate for Group Homes of Four Beds or Less Increased by 25 Percent	**14.02**	**16.12**
Option 2B - Congregate Residential Rate for Group Homes of Four Beds or Less Increased by 10 Percent	**14.80**	**17.02**

ROS - Rest of State; NOVA – Northern Virginia

Operational Impact

DMAS will establish and require billing codes for sponsored residential services separate from congregate residential.

Reimbursement for In-Home Residential

Residential in-home supports provide an individual with the opportunity to remain in a family or own home environment and receive one-to-one supports. In their 2007 report, DBHDS stated that in-home residential support is an underutilized service in the (then) MR Waiver. In May 2011 there were approximately 1,128 individuals receiving in-home services in the ID waiver and 136 individuals receiving in-home residential services in the DD waiver. The option of in-home services enables more person-centered planning by providing individuals with developmental disabilities community choices over their residence and services. This is the only residential service available to individuals in the DD waiver. Reimbursing in-home services at a substantially higher rate would continue to promote the outcome of individuals with developmental disabilities remaining with their family and encourage further utilization of in-home supports.

In-Home Residential Rate Options

DBHDS recommendations discussed in the group home section for either a 25-percent or 10-percent rate increase included the in-home residential model. These are the options modeled in this report. Intuitively, reimbursement for a service with a staffing ratio of one-to-one should be higher than reimbursement for a service with a congregate staffing model though it is difficult to compare the two models since the economics of a group homes model is more complex than the economics of an in-home residential model. The options modeled in Table 9 would maintain a differential of 31 percent between in-home residential and congregate residential for group homes of four beds or less.

Table 9: In-Home Residential Rate Options

In-Home Residential Rate	ROS	NOVA
Current	19.65	22.59
Option 3A - Increase Rate by 25 Percent	**24.56**	**28.24**
Option 3B - Increase Rate by 10 Percent	**21.62**	**24.85**

Rates under these options can be compared to the in-home residential rates proposed by JLARC in its 2006 report (see Appendix H for a summary of the report). JLARC developed a range of rates using a Living Wage approach and a Comparable Position approach. Rates for 2006 were updated consistent with the methodologies described in the report using the Consumer Price Index (CPI) to update the Living Wage and the nursing facility inflation index to update the comparable position. The rate for Living Wage and Comparable Position were not recalculated, however, so they may not fully reflect the current conditions. For example, the Comparable Position was pegged to state salaries for comparable positions. Since state salaries have been frozen for several years, the rates for Comparable Position updated to 2013 using the nursing home inflation may be overstated.

Rate ranges for the JLARC Living Wage and Comparable Position approaches are presented below in Table 10 for 2006 and updated to 2013 along with in-home residential rate options. Rates under Option 3A (25 percent rate increase) are within or above the range for the Living Wage approach and close to the bottom of the range for the comparable position approach. Rates under Option 3B (10 percent rate increase) are within the range for the Living Wage approach in ROS and a little below the range for the Living Wage approach in NOVA.

Table 10: JLARC Approaches – Living Wage / Comparable Position

	JLARC Living Wage Approach		**JLARC Comparable Position Approach**	
	ROS	NOVA	ROS	NOVA
2006	$15.46 to $19.51	$22.38 to $28.25	$22.22 to $27.13	$24.86 to $30.47
Updated to 2013	$18.00 to $22.71	$26.05 to $32.88	$26.23 to $32.02	$29.34 to $35.97
Compared to In-Home Residential Rate Options				
3A-25% Rate Increase	$24.56	$28.24	$24.56	$28.24
3B-10% Rate Increase	$21.62	$24.85	$21.62	$24.85

Reimbursement for Exceptional Residential Needs

In an effort to adopt more person-centered practices, DBHDS began phasing in the use of the Supports Intensity Scale (SIS) beginning in 2009 with a goal of full implementation across the ID and DS Waivers by 2012. Developed by the American Association on Intellectual and Developmental Disabilities, the SIS is a standardized assessment process used to measure the trends and intensity of supports that would be necessary for persons with intellectual or developmental disabilities to be successful. The SIS is a structured interview administered by professionals specifically trained in SIS administration. The SIS is a unique assessment instrument; measuring the frequency and level of support needs rather than deficits.

The SIS categorizes support needs. The data that has been obtained and categorized so far has determined six categories of support needs. Once all assessments have been completed in 2012, the number of categories may drop to five or four based on recommendations by consultants at the Human Services Research Institute who are working with DBHDS. However, it is not expected that the percent of highest needs within the state will change. In category one are individuals with fewer support needs and those in category six typically have exceptional behavioral and/or medical support needs. Table 11 shows the percentage of individuals by SIS categories for each waiver residential setting and the training centers.

Table 11: Percentage of Individuals by Residential Setting in the ID Waiver or Training Centers by SIS Category

SIS Categories	1	2	3	4	5	6	Total
Group home	42%	31%	4%	12%	2%	9%	100%
Sponsored residential	27%	31%	12%	12%	5%	12%	100%
In-home	52%	26%	5%	6%	8%	3%	100%
Training Centers	15%	44%	10%	9%	15%	8%	100%

In response to the legislative directive to "enable individuals with high medical needs and/or high behavioral support needs to remain in the community setting of their choice," this report offers the model of an enhanced rate for high needs individuals receiving supports in a group home, through sponsored residential or in-home residential settings. The term "exceptional rate" will be used to refer to this enhanced rate.

Currently, DBHDS generally authorizes more hours of service for individuals with higher needs than for individuals with lower needs. While some individuals have less than 20 hours of service a week, a few individuals have authorized hours of service of 24/7. It is true of all three residential settings, though individuals in the family home on average receive less than half the hours of services authorized for those in group homes or sponsored residential.

Even with high authorized service hours, payment may not be enough to reflect the service cost for some individuals. The congregate residential rate does not assume 1:1 supervision most of the time. Staff ratios in group homes vary during the day from 1:1 or 1:2 during the busy times related to dressing or meals to lower ratios during less busy times of the day. The mix and number of individuals in the home is also a critical factor for determining the staffing needed. For example, the tendency to have behavioral conflicts may be greater the more individuals that are in the home. While in-home residential already operates on a 1:1 basis, there may be times when 2:1 is necessary.

It is not common, but DBHDS has estimated that there are three to five percent of individuals currently in the waiver who need additional residential supports. This issue is even more critical for individuals in state training centers. DBHDS has estimated that 15 to 20 percent of those in the state training centers will need additional residential supports to successfully transition to the community.

There are individuals in the state training centers who are similar to individuals being served in the community, but it is harder to find enough placements for all these individuals. Using an estimate of four percent of the 7,753 individuals in the ID waiver, 310 individuals with the highest need would receive the exceptional rate. If Virginia moves all 1,100 residents in training centers to the community and 17.5 percent of them have an intense level of need, 193 additional beds (62 percent more beds) will be required for individuals who would be eligible for the exceptional rate.

Exceptional rate differentials could be available across all residential settings. Sponsored residential has a much higher percentage (12 percent) of individuals with the highest SIS scores compared to in-home residential (three percent), and is even higher, somewhat surprisingly, than the group home model (nine percent). As mentioned above, however, additional residential supports may be something different for sponsored residential or group homes. Consistent with the overall policy of promoting smaller group homes, the exceptional rate, when paid for individuals in group homes, should only be paid when the individual is residing in a group home of four beds or less.

Two exceptional rate categories are being considered. DBHDS and DMAS are drafting criteria for the exceptional rate. At this time, it is not possible to confirm the estimates above of the number of individuals who would qualify. Of those whose needs justify an exceptional rate, most would qualify for exceptional rate Category 1. A very small number would likely qualify for exceptional rate Category 2, which would probably be consistent with the reimbursement DMAS occasionally pays for a few waiver eligible individuals placed in institutions out-of-state (because no such facilities exist in the Commonwealth). At a minimum, individuals qualifying for the exceptional rate would have the highest score on the Supports Intensity Scale (an alternative would be developed for children under age 16, for whom there is not yet a normed SIS). Additional criteria could include repeated acute psychiatric hospitalizations and repeated failures in the community, for example.

DBHDS and DMAS may need additional resources to accommodate the evaluation of individuals for the exceptional rate, depending on the criteria. The assumption is that evaluations would be done more frequently than once a year, which is the frequency for plans of care for most waiver services. It is possible that the exceptional rate would only be needed during a transition, at least for some individuals. Individual behaviors sometimes improve when in stable home environments.

Another challenge is defining required services and developing a way to monitor the provision of those services. If the state provides additional reimbursement, providers will be expected to furnish additional care. Presumably, this is primarily additional residential supports, such as more one-to-one supervision for those in group homes. Additional residential supports may be represented by something different for sponsored residential versus group homes.

Exceptional Rate Options

Options under consideration are an exceptional rate differential of 25 percent for Category One and 50 percent for Category Two. However, the differentials will depend on the yet to be defined service requirements. The actual rates depend on the options for the congregate residential rate for four beds or less, the sponsored residential rate and the in-home residential rate. The two tables below summarize all the rate options, including the exceptional rate options. Table 12 includes options to increase the congregate residential rate for group homes of four beds or less and in-home residential rates by 25 percent with a corresponding change to sponsored residential rates so that they are 25 percent lower than the congregate residential rates for group homes of four beds or less.

Table 12: Option 4A - Base Rates and Exceptional Rate Assuming 25% Increase in Rates for 4-Bed Group Homes and In-Home

Option 4A - Exceptional Rates					
	Region	Current Rate	New Base Rate	**Exceptional Rate-Category One**	**Exceptional Rate-Category Two**
Option 1A-Congregate Residential	NOVA	$17.19	$21.49	**$26.86**	**$32.24**
	ROS	$14.95	$18.69	**$23.36**	**$28.04**
Option 2A-Sponsored Residential	NOVA	$17.19	$16.12	**$20.15**	**$24.18**
	ROS	$14.95	$14.02	**$17.53**	**$21.03**
Option 3A-In-Home Residential	NOVA	$22.59	$28.24	**$35.30**	**$42.36**
	ROS	$19.65	$24.56	**$30.70**	**$36.84**

Table 13 includes options to increase the congregate residential rate for group homes of four beds or less and in-home residential rates by 10 percent with

corresponding changes to sponsored residential rates so that they are 25 percent lower than the congregate residential rates for group homes of four beds or less.

Table 13: Option 4B - Base Rates and Exceptional Rate Assuming 10 Percent Increase in Rates for 4-Bed Group Homes and In-Home

Option 4B - Exceptional Rates With 10-Percent Increase to Congregate Residential Rates					
	Region	Current Rate	New Base Rate	**Exceptional Rate-Category One**	**Exceptional Rate-Category Two**
Option 1A-Congregate Residential	NOVA	$17.19	$18.91	**$23.51**	**$28.37**
	ROS	$14.95	$16.45	**$20.56**	**$24.68**
Option 2A-Sponsored Residential	NOVA	$17.19	$14.18	**$17.73**	**$21.27**
	ROS	$14.95	$12.33	**$15.41**	**$18.50**
Option 3A-In-Home Residential	NOVA	$22.59	$24.85	**$31.06**	**$37.28**
	ROS	$19.65	$21.62	**$27.03**	**$32.43**

ROS - Rest of State; NOVA – Northern Virginia

Operational Impact

DMAS would add an exceptional rate indicator to the Level of Care file and price the claims for the three different residential services to pay at the higher rate for all individuals with that indicator.

Fiscal Impact

The rate section of the report presents a number of options for modifying rates for residential services for individuals in the ID and DD waivers. This section summarizes the fiscal impact of these options. Implementing any of these options (or a variation) is contingent on funding authorized in the annual budget adopted by the General Assembly and approved by the Governor. The fiscal impact includes total funds and general funds. Since the federal government funds 50 percent of Medicaid expenditures in Virginia, the general fund budget is 50 percent of the total funds.The first part of this section is the fiscal impact for the current waiver. In addition, there is the fiscal impact on the cost of new slots. The current slot costs are based on current rates. If rates are modified, the slot costs will change. There are separate slot costs for the waiting list and for those in the training centers.

Changes could also be phased in. For example, a 25-percent rate increase for congregate residential for four beds or less could be implemented in three equal rate increases over three years. This would make it easier to build into the budget. An

additional option is to implement the ten percent rate increase with the intention of evaluating the results in two to three years. If the ten percent rate increase for congregate residential for four beds or less is resulting in the desired availability of smaller group homes, higher rate increases may not be needed immediately.

Fiscal Impact of Congregate Residential Rate Proposals (including Sponsored Residentia1)

The fiscal impact of increasing congregate residential services is presented as two options in Table 14, a 25 percent increase and a ten percent increase to the current congregate residential rate. The sponsored residential fiscal impact reflects for each option that the sponsored residential rate would be 25 percent lower than the congregate residential rate. As indicated above, the 25-percent increase would only apply to licensed group homes of 4 beds or less. The estimate also incorporates the conversion logic that 100 percent of five-bed and 50 percent of group homes with six beds or more would convert to four-bed group homes, an 18.2 percent increase to congregate residential expenditures. The ten-percent rate increase assumes the same provider conversion logic, producing an increase of approximately 7.3 percent.

Table 14: Fiscal Impact of Increasing Congregate Residential Service Rates

	Total Funds	General Funds	Non-General Funds
Congregate Residential (Group Homes of 4 beds or less)			
25-Percent Increase	**$53,129,273**	**$26,564,637**	**$26,564,637**
10-Percent Increase	**$21,251,709**	**$10,625,855**	**$10,625,855**
Sponsored Residential (25% less than the 4-bed group home rate)			
25-Percent Increase	**($4,168,148)**	**($2,084,074)**	**($2,084,074)**
10-Percent Increase	**($666,904)**	**($333,452)**	**($333,452)**
Net Impact			
25-Percent Increase	**$48,961,125**	**$24,480,563**	**$24,480,563**
10-Percent Increase	**$20,584,806**	**$10,292,403**	**$10,292,403**

Fiscal Impact of In-Home Rate Proposals

The fiscal impact of increasing in-home residential services is presented as two options in Table 15, a 25-percent increase and a 10-percent increase to the current in-home residential rate.

Table 15: Fiscal Impact of Increasing In-Home Residential Service Rates

In-Home Residential	Total Funds	General Funds	Non-General Funds
25-Percent Increase	**$13,657,021**	**$6,828,510**	**$6,828,510**
10-Percent Increase	**$5,462,808**	**$2,731,404**	**$2,731,404**

Fiscal Impact of Exceptional Rate Proposals

The fiscal impact of the applying an exceptional rate for each residential rate increase assumes a 25 percent add-on for each rate option. The cost estimate for the Exceptional Rate options in Table 16 includes only a cost estimate for Exceptional Rate-Category One.

Table 16: Fiscal Impact of Exceptional Rate Category One

Exceptional Rate-Category One	Total Funds	General Funds	Non-General Funds
Congregate Residential			
Option 4A	**$5,570,557**	**$2,785,279**	**$2,785,279**
Option 4B	**$4,902,090**	**$2,451,045**	**$2,451,045**
Sponsored Residential			
Option 4A	**$921,875**	**$460,938**	**$460,938**
Option 4B	**$973,500**	**$486,750**	**$486,750**
In-Home Residential			
Option 4A	**$2,990,537**	**$1,495,268**	**$1,495,268**
Option 4B	**$2,631,672**	**$1,315,836**	**$1,315,836**
Net Impact			
Option 4A	**$9,482,969**	**$4,741,485**	**$4,741,485**
Option 4B	**$8,507,262**	**$4,253,631**	**$4,253,631**

Fiscal Impact on Waiver Slots for Waiting List and Training Center Population of Various Proposals

The fiscal impact of revising rates for congregate residential and in-home residential services is presented as two options in Table 17, a 25-percent increase and a 10-percent increase to the current congregate and in-home residential rates. The impact on cost per waiver slot is estimated for the individuals on the waiting list and individuals in the training centers. The exceptional rate generates additional costs per slot for both of these scenarios.

Table 17: Fiscal Impact of Increasing Congregate and Sponsored Residential Rates per New Waiver Slot

Congregate and Sponsored Residential Per Slot Costs			
	Total Funds	**General Funds**	**Non-General Funds**
Waiting List			
25-Percent Increase	**$7,652**	**$3,826**	**$3,826**
10-Percent Increase	**$1,658**	**$829**	**$829**
Training Center			
25-Percent Increase	**$14,744**	**$7,372**	**$7,372**
10-Percent Increase	**$3,195**	**$1,597**	**$1,597**
Exceptional Rate Per Slot Cost			
	Total Funds	**General Funds**	**Non-General Funds**
Waiting List			
25-Percent Increase	**$2,195**	**$1,097**	**$1,097**
10-Percent Increase	**$1,932**	**$966**	**$966**
Training Center			
25-Percent Increase	**$4,229**	**$2,114**	**$2,114**
10-Percent Increase	**$3,723**	**$1,862**	**$1,862**

The changes in the in-home residential rates will also increase slot costs for both the ID and DD Waivers shown in Table 18. The additional slot costs for in-home residential services are not differentiated by individuals on the waiting list and training center discharges.

Table 18: Fiscal Impact of Increasing In-Home Residential Rates per New Waiver Slot

In-Home Residential Per Slot Costs			
	Total Funds	**General Funds**	**Non-General Funds**
25-Percent Increase	**$1,193**	**$597**	**$597**
10-Percent Increase	**$477**	**$239**	**$239**
Exceptional Rate Per Slot Cost			
	Total Funds	**General Funds**	**Non-General Funds**
25-Percent Increase	**$261**	**$131**	**$131**
10-Percent Increase	**$230**	**$115**	**$115**

Options for Improved Services under the Day Support (DS) Waiver

Virginia's DS Waiver serves individuals with intellectual disability (ID) and was developed in 2005 to assist individuals waiting for services through the ID Waiver. There are 300 slots in the DS Waiver and waiver services are limited to day support, prevocational services and supported employment. Not all of the DS Waiver slots are filled; as of July 1, 2011 there were 272 individuals enrolled.[4] One reason for the low enrollment may be that the current array of services does not optimally assist individuals and families with accomplishing the day to day activities essential for community living.

Virginia could strengthen this waiver by adding an additional array of services. DMAS and DBHDS solicited stakeholder input regarding short-term enhancements to the DS Waiver (see Appendix E for a summary of the comments). In response to the request to identify the five services that, if added, would increase value to the DS Waiver, participants overwhelming identified the following services as needed to better support individuals and families in their homes:

Assistive Technology - specialized medical equipment and supplies to include devices, controls or appliances specified in the individual support plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Crisis Stabilization - a direct intervention to individuals with ID who are experiencing serious psychiatric or behavioral challenges that jeopardize their current living situation

Personal Assistance - a service designed to assist an individual with activities of daily living (eating, bathing, dressing, toileting, transferring) and instrumental activities of daily living (meal preparation, shopping, housekeeping, laundry, money management) when the individual is unable to perform these functions.

Respite - a short-term service to assist the individuals in the absence of the unpaid caregiver.

Therapeutic Consultation - provides supports to the individual, family, staff of service providers with implementing an individual support plan.

In order to effectuate the enhancement of the DS Waiver by adding these five additional services, there will be operational and fiscal impacts described below. It should be noted that if Virginia moves forward with long-term changes to the ID and DD waivers (discussed below), it may not be prudent to devote resources to modifying the DS Waiver as described. In fact, a significant amount of stakeholder input questioned the

[4] DMAS Division of Long-Term Care Weekly Management Report July 1, 2011.

usefulness of modifying the DS Waiver and supported a more comprehensive approach (see Appendix E). However, without certainty regarding the implementation of long-term changes to the ID and DD waivers, modification of the DS Waiver as described may still provide a benefit to those able to utilize the enhanced waiver.

Operational Impact

Implementing additional services in the DS Waiver will require operational changes to policy and procedures. DMAS, in collaboration with DBHDS, will need to submit a waiver amendment to CMS to expand the array of available services. The waiver amendment will define the scope of each service added, provider qualifications for the service and the projected cost. Also, the Virginia Administrative Code will require amendment to reflect the additional services, including criteria for receipt of the services and provider qualifications. System changes will be required to add billing codes to the DS Waiver which will allow providers of the added services to receive Medicaid reimbursement.

Fiscal Impact

Analysis indicates that these services, if applied to the DS Waiver as currently allocated (300 slots), would cost approximately $4.7 million total ($2.34 million GF) per year. The current DS Waiver annual cost per slot is $10,701; these changes would add $15,619 to that cost, for a total DS waiver annual cost of $26,320 per slot.

Potential Long-Term Waiver Modifications

Previous reports and input from stakeholders indicate that long-term changes could benefit the current ID, DS and DD Waivers. This section of the report discusses how other states have begun to address the challenges of meeting the support needs of individuals with developmental disabilities through significant modifications and structural changes to their waiver programs. Some states have made significant changes to their service delivery systems while attempting to offer a flexible array of services within the constraints of a challenging economy. For example, there has been movement in some states toward comprehensive waivers, addressing the entire population of individuals with developmental disabilities, including the intellectual disability through the full array of services (including multiple forms of residential services) available to individuals based on level of need. These combined comprehensive waivers are most often coupled with support waivers for those with lower level needs or those waiting for slots in the comprehensive waiver; supports waivers do not typically have any residential components.

Other State Experiences

Virginia's experience with developing and implementing 1915(c) waivers for individuals with developmental disabilities is not unlike that of many states. The Kaiser Commission reports that the provision of home and community-based services continue

to be a priority for many states even two decades since the passage of the Americans with Disabilities Act. With state budgets suffering from the current economy, all states reported using mechanisms to control costs, such as financial and functional eligibility standards, enrollment and service limits, waiting lists, and use of in-home and community-based services. For individuals with developmental disabilities, almost a quarter of a million individuals (nationally) are on waiting lists for these services.[5]

Supports waivers have evolved as a mechanism to offer services to individuals in their homes and communities. A supports waiver is a waiver that does not have a residential component among the array of services made available to qualifying individuals with developmental disabilities. In April 2007, there were 17 states with supports waivers.[6] A survey conducted by the DBHDS in January 2011 showed that the number of states with supports waivers had increased to 24 states. Virginia is included in the list of 24 states because Virginia's DS Waiver is considered a supports waiver that targets individuals with ID. Table 19 shows the states having a supports waiver for individuals with DD or ID.

Table 19: States that offer supports waiver for individuals with ID / DD

Alabama	Louisiana	Oregon
Colorado	Massachusetts	Pennsylvania
Connecticut	Missouri	South Carolina
Florida	Montana	South Dakota
Georgia	Nebraska	Tennessee
Illinois	North Carolina	Texas
Indiana	Ohio	Virginia
Kentucky	Oklahoma	Washington

All of the states in Table 19 have, in addition to a supports waiver, a comprehensive waiver. Comprehensive waivers differ from the supports waiver by offering residential (congregate) options to qualifying individuals. Comprehensive waivers tend to serve individuals with the highest need for services and supports. Generally, states have used the waiver renewal process as an opportunity to adjust existing waivers to reflect the changing needs of individuals with developmental disabilities and add supports waivers to complement an existing, comprehensive waiver.

The Departments of Medical Assistance Services and Behavioral Health and Developmental Services contacted Florida, Georgia and Pennsylvania to better understand the scope of the waiver services available, the administrative and operational structures, and the service delivery process used in these states. These states were selected as they vary in administrative structure and provision of services. The following

[5] Medicaid Home and Community-Based Services programs: Data Update, Kaiser Commission on Medicaid and the Uninsured, February 2011.
[6] Gauging the Use of HCBS Supports Waivers for People with Intellectual and Developmental Disabilities: Final Project, April 2007

paragraphs summarize information obtained during telephone calls with state waiver administrators.

Florida: The Florida Agency for Health Care Administration is the single state agency responsible for administration of Medicaid Program, including the 1915(c) waivers. Operational authority is delegated to the Agency for Persons with Disabilities (APD). APD was created in 2004 and specifically tasked with meeting the needs of persons with developmental disabilities. APD operates waivers serving individuals with developmental disabilities including autism and intellectual disability ages three years and older. Florida's DD[7] waivers have four tiers. Tiers I, II, and III serve individuals residing in a variety of settings (including residential settings); the individuals enrolled in these tiers require significant support services. Tier I serves individuals with the greatest need for supports and has no individual dollar cap. Tiers II and III are capped at $58,000 and $35,000 respectively. Tier IV, called the Family and Supported Living Waiver, serve individuals with DD and was initially capped at $14,792. In 2010 the Florida legislature reduced the cap to $14,411 per recipient (2.5%).

In March 2011, Florida received approval from CMS to begin a new waiver offering individualized budgeting to individuals in each of the four waivers described above. As with all new waivers, CMS approved Florida's request for three years, with a two and one-half year phase-in period. If successfully implemented, the Florida Developmental Disability Individual Budgeting Waiver will afford individuals with DD the authority fully manage the services authorized within their individually approved service plans.

Georgia: Georgia's state agencies have undergone, and continue to experience restructuring. The Georgia Department of Human Resources was divided to form the Department of Community Health which is the single state agency responsible for the administration of the Medicaid Program, including the 1915(c) waivers and the newly created Department of Behavioral Health and Developmental Disabilities is now responsible for coordinating services to individuals with developmental disabilities. In 2007, the state's former Intellectual Disability Waiver was converted into the New Options Waiver (NOW). A new waiver was created, the Comprehensive Supports Waiver (COMP), resulting in two 1915(c) waivers available to individuals with DD[8]. Both waivers offer identical services except that the COMP waiver offers residential options. The COMP waiver serves individuals with DD needing more intense supports and having services expenditures greater than $25,000 per year; NOW serves individuals having services expenditures of less than $25,000 per year. Individuals move from one waiver to the other when the need for services and expenditures increases or decreases.

Pennsylvania: The Pennsylvania Department of Public Welfare (DPW) is the umbrella agency responsible for administration and operation of 1915(c) and coordination of services to individuals with DD. Within the Pennsylvania DPW are two

[7] Florida includes within the definition of developmental disabilities individuals with ID and Autism Spectrum Disorders (ASD).
[8] Like the state of Florida, Georgia includes individuals with ID within the definition of DD.

offices: the Office of Medical Assistance Programs responsible for the 1915(c) waivers and the Office of Developmental Programs responsible for the operations of the 1915(c) waivers and coordination of services to individuals with DD. Pennsylvania has three waivers developed to provide supports to individuals with DD. The oldest waiver is the Pennsylvania Consolidated Waiver created in 1990 and serves individuals with ID and includes residential habilitation (similar to Virginia's congregate residential option in the ID Waiver). The Pennsylvania Person/Family Directed Support Waiver was added in 1999, having similar services as the Pennsylvania Consolidated Waiver, with the exception of there is no residential component. In 2008, Pennsylvania developed an Adult Autism Waiver, serving individuals with Autism Spectrum Disorders (ASD) age 21 years and older, for the explicit purpose of assuring that people with ASD have supports and services to assist them in leading successful, happy and safe lives in the community.[9] The Adult Autism Waiver includes a residential option and has more of a focus on job assessment/finding and transitional work.

Comprehensive and Supports Waivers in Virginia

Virginia's waivers have many of the design characteristics of the comprehensive and supports waivers described earlier in other states, except that they remain segmented between those with intellectual disability and the rest of the population of individuals with developmental disabilities.

Current Characteristics: The ID and DS Waivers create a comprehensive and support waiver system for the individuals with intellectual disability. The ID Waiver is a comprehensive waiver in that it has a large array of services including a residential component. Conversely, the DS waiver is a supports waiver (no residential component) with limited services offered, as discussed previously. For the remainder of those with developmental disabilities, the DD Waiver essentially serves as a support waiver (with no congregate residential component), albeit with a more robust array of other services (as compared with the DS Waiver).

The ID Waiver has more than ten times the number of approved waiver slots than the DD Waiver and more than five times the number of individuals who are waiting for services. The expenditures for the waivers reflect the greater number of slots available in the ID Waiver as well as the inclusion of a residential component in that waiver. Table 20 compares the expenditures and cost per individual in each waiver. Should Virginia elect to move toward serving individuals with DD, including individuals with ID, in the same waiver, some administrative, operational and service delivery differences (discussed below) would need to be addressed and overcome.

[9] Pennsylvania Adult Autism Waiver Application, 2008

Table 20: Expenditures for the ID, DS and DD Waivers[10]

Target Population / ID:	Individuals Served	Total Annual Expenditure	Average Cost Per Individual
ID Waiver	7,748	$485,106,854	$62,611
DS Waiver	283	$3,369,954	$11,908
Target Population / DD:			
DD Waiver	584	$15,372,085	$26,322

Existing Barriers: For Virginia to move forward with building a system for individuals with developmental disabilities (including ID) and their families, the following areas must be addressed and resolved along with necessary changes to the C*ode of Virginia* and/or the Virginia Administrative Code:

- Case Management. Should Virginia determine that CSBs may provide case management to all individuals with DD, Virginia will be required to describe to CMS the specific changes and how these changes will be accomplished by the state. Currently, case managers employed by Community Services Boards (CSBs) coordinate service delivery for individuals with ID through targeted case management (a State Plan Option service); private case managers for individuals with DD are enrolled as Medicaid providers under separate regulatory authority from that provided for CSBs.

  Preliminary discussions with stakeholders regarding the issue of case management presented an approach that would place the case management function for the DD population within the publically funded CSB system. Individuals receiving services would then have the option to select a CSB case manager or a licensed private case manager under contract to the CSB. This would expand the pool of qualified case managers and support an individual's choice of provider for this service.

- Wait Lists. Should Virginia determine that the 1915(c) waivers for the ID, DD and DS Waivers need to serve all individuals with DD, the Commonwealth must explain to CMS how the waiting list processes will work and provide a transition plan for accomplishing the change. Currently, the waiting list for the ID Waiver is based on need using statewide criteria applied by the CSB case manager; the DS and DD Waivers serve individuals on a first come, first service chronological) basis determined by the date the need for services was identified. The same cross-system stakeholder work group that developed a plan for a blended case management system also proposed a process by which the wait list could be blended that seemed to hold promise as a reasonable approach.

[10] *Cost-effectiveness Summary of Virginia's 1915(c) Home- & Community-Based Waivers SFY 2009 – Initial Reports*

- Operational Authority. Should Virginia determine that operational authorities for the ID, DS or DD Waiver need to change, the Commonwealth must identify the changes needed, how the changes will be accomplished and provide assurance to CMS that waivers will continue be in compliance with all federal requirements. Currently, State operational responsibilities of the ID, DS and DD Waivers are different. All 1915(c) waivers, along with all other Medicaid programs, must be administered by a single state agency designated by that state as responsible to CMS. In Virginia, the Commonwealth has designated DMAS as that agency. In 2006, DMAS and DBHDS agreed that certain operational authorities for ID and DS Waivers would be delegated by DMAS to DBHDS, similar to the agreement that existed from FY 1991 to FY 2000. Currently, all operational authority for the DD Waiver rests with DMAS.

- Prior Authorization. Should Virginia determine that service authorization functions for the ID, DS or DD Waiver need to change, the Commonwealth must identify those changes, how the changes will be accomplished and continue to assure CMS that the Commonwealth will continue to be in compliance with all federal requirements. Change may include changes in existing contracts for the service authorization function as well as the Interagency Agreement (IAG) between DMAS and DBHDS.

Major structural and service delivery changes such as those described above would best be accomplished through the waiver renewal process. The DD and DS Waivers are scheduled for renewal by July 1, 2013; the ID Waiver must be renewed by July 1, 2014. In addition to making required changes that might be identified by CMS, Virginia has the opportunity to identify additional changes to update the ID, DS and DD Waivers. DMAS and DBHDS propose to work with stakeholders over the next several months to provide specific recommendations for the long-term modifications to the ID, DS and DD Waivers, with a goal of providing a report to the Secretary of Health and Human Resources and the Governor for consideration in the FY 14-16 biennial budget development.

Summary and Conclusions

Virginia, like many other states, is working to address the needs of individuals with developmental disabilities, including intellectual disability, during challenging economic times. Medicaid home and community-based services waivers have offered states the benefit of flexibility to design service delivery systems to meet the unique needs of each state while using federal matching funds to enhance available resources. However, Medicaid waivers have detailed federal guidelines to which states must adhere to avoid financial penalties. Virginia has worked successfully with the Centers for Medicare and Medicaid Services (CMS) to provide evidence of the Commonwealth's successful performance in the administration of the ID, DS and DD Waivers.

The Commonwealth is at a crossroads. Within the next three years, the ID, DS and DD Waivers must be renewed by CMS in order for Virginia to continue to make waiver services available to individuals with DD/ID and their families. The waiver renewal process can be a simple renewal of the current waivers for another five years; or, the renewal process can offer states the opportunity to renew and replace older waivers with new waivers to more comprehensively address the changing needs of individuals and families. Additionally, certain modifications, such as the rates and service adjustments articulated in this report, can bridge the gap under the current structure until a new structure is implemented.

The many challenges facing Virginia's ID, DS and DD Waiver programs can be overcome. Virginia has a very active and dedicated community of stakeholders willing to identify needed changes and advocate for resources. Even in a strapped economy, with continuing collaboration and focus throughout the upcoming waiver renewal process, Virginia can achieve a greater shift from the institutionally based system of the past to the community-based, person-centered service delivery system desired by individuals with DD / ID and their families now and for the future.

Appendix A

Study Mandate

BBBBB. The Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services, in consultation with appropriate stakeholders and national experts, shall research and work to improve and/or develop Medicaid waivers for individuals with intellectual disabilities and developmental disabilities that will increase efficiency and cost effectiveness, enable more individuals to be served, strengthen the delivery of person-centered supports, enable individuals with high medical needs and/or high behavioral support needs to remain in the community setting of their choice, and provide viable community alternatives to institutional placement. This initiative shall include a review of the current Intellectual Disabilities (ID), Day Support and Individual and Family Developmental Disabilities Supports (DD) waivers to identify any improvements to these waivers that will achieve these same outcomes. The Department of Behavioral Health and Developmental Services and the Department of Medical Assistance Services shall report on the proposed waiver changes and associated costs to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2011.

Appendix B

Mental Retardation/Intellectual Disability (MR/ID) Waiver Fact Sheet 2011

Initiative	Home- and community-based (1915 (c)) waiver the purpose of which is to provide care in the community rather than in an intermediate care facility for persons with mental retardation (ICF/MR).
Targeted Population	Individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have mental retardation/intellectual disability (MR/ID). All individuals must: (1) Meet the ICF/MR level of care criteria (i.e., meet two out of seven levels of functioning in order to qualify); (2) Be at imminent risk of ICF/MR placement; and (3) Be determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in an ICF/MR.
Program Administration	Program is administered by the Department of Behavioral Health and Developmental Services (DBHDS) and DMAS.
Eligibility Rules	The individual must be eligible for Medicaid and meet screening criteria; the income limit is 300% of the SSI payment limit for one person. The individual must meet criteria for ICF/MR; and must have MR/ID or related condition OR under age 6 at developmental risk who requires a level of care in an ICF/MR (at age 6, the child must have MR/ID); and must meet at least two level-of-functioning indicators.
Services Available	• Adult Companion Care – Agency-Directed and Consumer-Directed • Assistive Technology • Congregate Residential • Crisis Stabilization • Crisis Supervision • Day Support – Regular and High Intensity • Environmental Modifications • In-Home Residential • Medication Monitoring (can only be received in conjunction with PERS) • Personal Emergency Response System (PERS) – Installation and Monthly Monitoring) • Personal Care – Agency-Directed and Consumer-Directed • Prevocational Services – regular and high intensity • Residential Support • Respite Care – Agency-Directed and Consumer-Directed (720 hours max/year) • Skilled Nursing RN and LPN • Supported Employment – Enclave and Individual • Therapeutic Consultation • Transitional Services

Service Providers	An institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS, and has a current, signed contract with DMAS to be a provider of waiver services.
Service Authorization	An individual or the individual's representative requests to be screened at the local community services board (CSB). The CSB is the single point of entry for MR/ID services.
Waiting List	A waiting list does exist for the MR/ID Waiver. The waiting list is maintained as follows: All CSBs/Behavioral Health Authorities (BHAs) are responsible for maintaining their own waiting list for the MR/ID Waiver. The waiting list maintained by the CSB/BHA consists of three categories: urgent, non-urgent, and the planning list. DBHDS will maintain the Statewide Waiting List to include the CSBs' urgent and non-urgent lists. The urgent category criteria are outlined later in this section. The non-urgent category consists of those who meet the diagnostic and functional criteria for the waiver, including the need for services within 30 days, but who do not meet the urgent criteria. The planning list category consists of those who need services in the future. The waiver is "needs based" with those in the urgent category being given priority. Only after all individuals in the State who meet the urgent criteria have been served can individuals in the non-urgent category be served. The CSB/BHA must maintain documentation with the reasons the individual meets the urgent criteria. If a slot becomes vacant or when a new slot is allocated, the CSB/BHA is responsible for assigning the slot to an individual from the urgent category. DBHDS will confirm that the slot is available to the CSB/BHA and that the individual has previously been included on the Statewide Urgent Need of Waiver Services Waiting List or newly meets the Urgent Need criteria. The CSB/BHA will determine, from among the individuals included in the urgent category, who should be served first, based on the needs of the individual at the time a slot becomes available and not on any predetermined numerical or chronological order. The urgency of need of individuals on the CSB's/BHA's waiting list is evaluated quarterly by the case manager, who makes additions and deletions to the urgent and non-urgent categories as needed and forwards to DBHDS any modifications to the Statewide Urgent Need of Waiver services Waiting List. When the individual is first placed on the Waiting List or if an individual is moved from the urgent to non-urgent waiting list category, he or she is to be notified in writing by the case manager within 10 days and given appeal rights.
Urgent Criteria	The urgent category is assigned when the individual is in need of services because he or she is determined to be at significant risk. Assignment to the urgent category may be requested by the individual, his or her legal guardian, or primary caregiver. The urgent category may be assigned only when the individual or legal guardian would accept the preferred service if it were offered. Satisfaction of one or more of the following criteria shall create a presumption that the individual is at significant risk and indicate that the individual should be placed on the Urgent Need of Waiver Services Waiting List: • Primary caregiver(s) is/are 55 years or older;

	• The individual is living with a primary caregiver who is providing the service voluntarily and without pay and the primary caregiver indicates that he or she can no longer care for the individual with mental retardation; • There is a clear risk of abuse, neglect, or exploitation; • The primary caregiver has a chronic or long term physical or psychiatric condition or conditions which significantly limit his or her ability to care for the individual with MR/ID; • The individual is aging out of a publicly funded residential placement or otherwise becoming homeless (exclusive of children who are graduating from high school); or • The individual with MR/ID lives with the primary caregiver and there is a risk to the health or safety of the individual, primary caregiver, or other individual living in the home due to either of the following conditions: 1. The individual's behavior or behaviors present a risk to himself or others which cannot be effectively managed by the primary caregiver even with generic or specialized support arranged or provided by the CSB/BHA; or 2. There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the primary caregiver even with generic or specialized supports arranged or provided the CSB/BHA.
Definitions (12VAC30-120-211)	**"Assistive technology"** means specialized medical equipment and supplies to include devices, controls, or appliances, specified in the consumer service plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the Medicaid State Plan. **"Case management"** means the assessing and planning of services; linking the individual to services and supports identified in the consumer service plan; assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the consumer service plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the consumer service plan. **"Companion services"** means nonmedical care, support, and socialization, provided to an adult (age 18 and over). The provision of companion services does not entail hands-on care. It is provided in accordance with a therapeutic goal in the consumer service plan and is not purely diversional in nature. **"Consumer-directed model"** means services for which the individual and the

	individual's family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the staff. **"Crisis stabilization"** means direct intervention to persons with mental retardation who are experiencing serious psychiatric or behavioral challenges that jeopardize their current 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 shall be 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"** means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level. **"Environmental modifications"** means physical adaptations to a house, place of residence, primary vehicle or work site (when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act) that are necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual. **"Personal assistance services"** means assistance with activities of daily living, instrumental activities of daily living, access to the community, self-administration of medication, or other medical needs, and the monitoring of health status and physical condition. **"Personal emergency response system (PERS)"** is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. **"Prevocational services"** means services aimed at preparing an individual for paid or unpaid employment. The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage. **"Residential support services"** means support provided in the individual's home by a DMHMRSAS-licensed residential provider or a DSS-approved provider of adult foster care services. This service is one in which training, assistance, and supervision is routinely provided to enable individuals to maintain or improve their health, to develop skills in activities of daily living and safety in the use of community resources, to adapt their behavior to community and home-like

	environments, to develop relationships, and participate as citizens in the community. **"Respite services"** means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care. **"Skilled nursing services"** means services that are ordered by a physician and required to prevent institutionalization, that are not otherwise available under the State Plan for Medical Assistance and that are provided by a licensed registered professional nurse, or by a licensed practical nurse under the supervision of a licensed registered professional nurse, in each case who is licensed to practice in the Commonwealth. **"Supported employment"** means 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"** means activities to assist the individual and the individual's family/caregiver, as appropriate, staff of residential support, day support, and any other providers in implementing an individual service plan. **"Transition services"** means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.
Quality Management Review	DMAS shall conduct quality management reviews of the services provided and interview individuals for all providers providing services in this waiver to ensure the health and safety of all individuals. Level of functioning reviews shall be performed at least annually.
Reimbursement Rates	Reimbursement rates can be found on the DMAS website at *www.dmas.virginia.gov/ltc-home.htm*.
Number of People Served (SFY2009)	7,748*
Total Waiver Expenditures (SFY2009)	$485,106,854*
Average Cost Per Individual (SFY2009)	$62,611*

Regulatory Basis	12VAC30-120-211 et seq.
Program Contacts	Ms. Gail Rheinheimer of DBHDS at (540) 981-0697 or by e-mail at grheinheimer@dbhds.state.va.us. Information can also be found on the DMAS website at www.dmas.virginia.gov..

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Appendix C

Day Support Waiver
Fact Sheet 2011

Initiative	Home and community-based (1915 (c)) waiver whose purpose is to provide supportive care in the community for individuals who are on the mental retardation/intellectual disability (MR/ID) waiting list.
Targeted Population	Individuals on MR/ID waiting list who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have MR/ID.
Program Administration	Program is administered by Department of Behavioral Health and Developmental Services (DBHDS) and DMAS.
Eligibility	Individuals on the MR/ID Waiver Urgent or Non-Urgent Waiting Lists are eligible if they have a MR/ID diagnosis. Individuals are selected according to the date when services were first necessary, regardless of urgency. An individual can remain on the waiting list for the MR/ID Waiver while being served by the Day Support Waiver and transfer to the MR/ID Waiver once a slot becomes available.
Services Available	Services include: • Day Support • Prevocational services • Supported Employment
Service Authorization	An individual or the individual's family/caregiver requests to be screened at his or her local Community Services Board (CSB). The CSB is the single point of entry for MR/ID services.
Definitions (12VAC30-120-1500)	**"Day support services"** means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level. *Day Support High Intensity:* To receive an intensive level of the day support services, an individual must meet one of the following criteria: require physical assistance to meet basic personal care needs; have extensive disability-related difficulty and require additional support to fully participate in programming and accomplish daily service goals; or require extensive personal care to reduce or eliminate behavior that prevents participation in programming (this requires behavioral program or objective) *(from 2007 Fact Sheet).* **"Prevocational services"** means services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general

	work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services (excluding supported employment programs). The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage. *Prevocational Services Intensive:* To receive an intensive level of prevocational services, an individual must meet one of the following criteria: require physical assistance to meet basic personal care needs; have extensive disability-related difficulty and require additional support to fully participate in programming and accomplish daily service goals; or require extensive personal care to reduce or eliminate behavior that prevents participation in programming (this requires behavioral program or objective) *(from 2007 Fact Sheet).* **"Supported employment"** means 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.
Quality Management Review	DMAS shall conduct quality management reviews of the services provided and interview individuals for all providers providing services in this waiver to ensure the health and safety of all individuals. Level of functioning reviews shall be performed at least annually.
Reimbursement Rates	Reimbursement rates can be found on the DMAS website at *www.dmas.virginia.gov/ltc-home.htm*.
Number of People Served (SFY2009)	283*
Total Waiver Expenditure (SFY2009)	$3,369,954*
Average Cost Per Individual (SFY2009)	$11,908*
Regulatory Basis	12VAC30-120-1500 et seq.
Program Contacts	Ms. Gail Rheinheimer of DBHDS at (540) 981-0697 or by e-mail at grheinheimer@dbhds.state.va.us Information can also be found on the DMAS website at www.dmas.virginia.gov.

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Appendix D

The Individual and Family Developmental Disabilities Support (DD) Waiver Fact Sheet 2011

Initiative	Home and community-based (1915(c)) waiver whose purpose is to provide care in the community rather than in an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR).
Targeted Population	Individuals who are 6 years of age and older who have a related condition and do not have a diagnosis of mental retardation/intellectual disability (MR/ID) who: (1) meet the ICF/MR level of care criteria (i.e., they meet two out of seven levels of functioning in order to qualify); (2) are determined to be at imminent risk of ICF/MR placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in an ICF/MR.
Program Administration	The program is administered by DMAS.
Eligibility	The DD Waiver provides services to participants 6 years of age and older who have a diagnosis of a related condition and do not have a diagnosis of MR/ID. Participants also must require the level of care provided in an intermediate-care facility for persons with ID/MR or other related conditions (ICF/MR). Children who do not have a diagnosis of MR/ID, and have received services through the MR/ID Waiver, become ineligible for the MR/ID Waiver when they reach the age of 6. At that time, they can be screened for eligibility for the DD Waiver; if found eligible, they may transfer to the waiver before the age of 7 and receive an DD waiver slot subject to Centers for Medicare and Medicaid Services (CMS) approval. Individuals remain on the MR/ID waiver until a smooth transition can take place.
Services Available	• Adult Companion Services – Agency-Directed • Assistive Technology • Case Management • Crisis Stabilization • Crisis Supervision • Day Support - High Intensity and Regular • Environmental Modifications • Family/Caregiver Training • In-home Residential Support (not group homes) • Personal Care – Agency-Directed and Consumer-Directed • Personal Emergency Response System (PERS) • Prevocational Training • Respite Care – Agency-Directed and Consumer-Directed • Skilled Nursing • Supported Employment – Enclave and Individual • Therapeutic Consultation

	• Transitional Services
Service Authorization	An individual or family/caregiver submits a "Request for Screening" form to the local Virginia Department of Health or Child Development Clinics designated to serve as the screening team for this waiver. If the screening team determines the individual meets criteria, the individual is offered the choice of DD Waiver case managers who will assist with service plan development and oversight. DMAS makes the final determination for waiver criteria and assigns the individual to the waitlist until a slot becomes available. Slot allocation is on a first come, first served basis.
Providers	An institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS, and has a current, signed contract with DMAS to be a provider of waiver services.
Waiting List	A waiting list exists for the DD Waiver. The waiting list is maintained on a first-come, first served basis. Individuals are assigned waiting list numbers based on the date DMAS receives all required documentation - the Screening Packet from the screening team and the plan of care from the case manager. Once the screening team determines the individual is eligible, a case manager works with the individual to develop a Plan of Care (POC). The amount of services on the POC determines which level waiting list the individual is assigned. Individuals whose POC are below $25,000 are assigned to Level I; POC exceeding $25,000 are assigned to Level II.
Emergency Criteria	Subject to available funding, individuals must meet at least one of the emergency criteria to be eligible for immediate access to waiver services without consideration to the length of time an individual has been waiting to access services. In the absence of waiver services, the individual would not be able to remain in his home. The criteria are: 1. The primary caregiver has a serious illness, has been hospitalized, or has died; or 2. The individual has been determined by the Department of Social Services (DSS) to have been abused or neglected and is in need of immediate waiver services; or 3. The individual has behaviors which present risk to personal or public safety; or 4. The child presents extreme physical, emotional or financial burden at home and the family or caregiver is unable to continue to provide care.
Definitions *(12VAC30-120-700 et seq.)*	"**Assistive technology**" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment. **"Case management"** means services as defined in 12VAC30-50-490.

	"Companion services" means nonmedical care, supervision and socialization provided to an adult (age 18 and older). The provision of companion services does not entail hands-on care. It is provided in accordance with a therapeutic goal in the plan of care and is not purely diversional in nature. **"Consumer-directed services"** means personal care, companion services, and/or respite care services where the individual or his family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the employee or employees. **"Crisis stabilization"** means direct intervention for persons with related conditions who are experiencing serious psychiatric or behavioral challenges, or both, that jeopardize their current community living situation. This service must provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize individuals and strengthen the current living situations so that individuals may be maintained in the community during and beyond the crisis period. **"Day support"** means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, services and support activities. These services take place outside of the individual's home/residence. **"Environmental modifications"** means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals. **"Family/caregiver training"** means training and counseling services provided to families or caregivers of individuals receiving services in the DD Waiver. **"In-home residential support services**" means support provided primarily in the individual's home, which includes training, assistance, and specialized supervision to enable the individual to maintain or improve his health; assisting in performing individual care tasks; training in activities of daily living; training and use of community resources; providing life skills training; and adapting behavior to community and home-like environments. **"Personal care services"** means long-term maintenance or support services necessary to enable individuals to remain in or return to the community rather than enter an Intermediate Care Facility for the Mentally Retarded. Personal care services include assistance with activities of daily living, instrumental activities of daily living, access to the community, medication or other medical needs, and monitoring health status and physical condition. This does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated

	in accordance with 18VAC90-20-420 through 18VAC90-20-460. **"Personal emergency response system (PERS)"** is an electronic device that enables certain individuals to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. **"Prevocational services"** are services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided for individuals who are not expected to be able to join the general work force without supports or to participate in a transitional, sheltered workshop within one year of beginning waiver services (excluding supported employment services or programs). Activities included in this service are not primarily directed at teaching specific job skills but at underlying rehabilitative goals such as accepting supervision, attendance, task completion, problem solving, and safety. **"Respite care"** means services provided for unpaid caregivers of eligible individuals who are unable to care for themselves and are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons who routinely provide the care. **"Skilled nursing services"** means nursing services (i) listed in the plan of care that do not meet home health criteria, (ii) required to prevent institutionalization, (iii) not otherwise available under the State Plan for Medical Assistance, (iv) provided within the scope of the state's Nursing Act (§ 54.1-3000 et seq. of the Code of Virginia) and Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia), and (v) provided by a registered professional nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state. Skilled nursing services are to be used to provide training, consultation, nurse delegation as appropriate and oversight of direct care staff as appropriate. **"Supported employment"** means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment. **"Therapeutic consultation"** means consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, or physical therapy or behavior consultation to assist individuals, parents, family members, in-home residential support, day support and any other providers of support services in implementing a plan of care. **"Transition services"** means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.
Quality	DMAS shall conduct quality management reviews of the services provided and

Management Review	interview individuals for all providers providing services in this waiver to ensure the health and safety of all individuals. Level of functioning reviews shall be performed at least annually.
Reimbursement Rates	Reimbursement rates can be found on the DMAS website at *www.dmas.virginia.gov/ltc-home.htm*.
Number of People Served (SFY2009)	584*
Total Waiver Expenditures (SFY2009)	$15,372,085*
Average Cost Per Recipient (SFY2009)	$26,322*
Regulatory Basis	12VAC30-120-700 et seq.
Program Contact	Ms. Tracy Stith Harris, Supervisor, DMAS Division of Long-Term Care, (804) 225-4791 or tracy.harris@dmas.virginia.gov. Information can also be found on the DMAS website at *www.dmas.virginia.gov*.

**Cost-effectiveness Summary of Virginia's 1915(c) Home- & Community-Based Waivers SFY 2009 – Initial Reports*

Appendix E

Stakeholder Input

Panel Comments

a) VACSB:
- Concern that the 4 bed rate increase proposal doesn't address the waiting list problem.
  - Concern that incentivizing smaller homes at the expense of those on the waiting list
  - Want the overall picture of where the Waiver is going vs. just parts of the puzzle. The present approach makes it difficult to respond appropriately.
  - Exceptional rate makes sense but only if all get services by qualified providers. Need to add services not fully covered, especially for those in need of medical support
  - Recommend examining increments of payment: smaller increments are unnecessarily burdensome to providers.

b) VACIL
  - Use resources for those on the waiting lists
  - Not supportive of a decrease in the SRS rate. Want to see SRS for DD Waiver individuals again.
  - Regarding the exceptional rate: NoVa families don't have In-home Residential providers for the DD Waiver due to CSBs supplementing the rate for those on the ID Waiver. This discrepancy will remain the same even with the exceptional rate.

c) VNPP
  - Not supportive of the assumption that 5 -6 bed group homes are financially viable due to individuals' medical needs, facility maintenance, repairs, modifications, etc. costs.
  - Supportive f differential rates
  - Recommend not using cost surveys. These only show providers good management skills.

d) The Arc of Virginia
  - Disappointed at the focus on group homes. Want to see more focus on In-home Residential, Respite, Personal Assistance, and Consumer Directed services
  - Need to address cost of living adjustments, DOJ recommendations, self determination, person-centered practices
  - Need more data to support conclusions
  - Do not believe the assumption that individuals in the training centers or on the waiting list predominantly want group homes. Address the In-home Residential rate and CD services more aggressively.
  - Do not support the assumption that 5 bed group homes are viable.
  - The proposed plan doesn't address the non-Waiver population.

- What will be the impact on those on the Waiting Lists
- The proposed plan doesn't address the DD population
- Request that experts be hired to study Virginia's situation and make recommendations (e.g., Charlie Lakin, David Braddock).
- Close the institutions and redirect the money.

e) VAccses
- Need to do both: address the waiting list and address the inequities in the community.
- The Residential reimbursement rates were based on false conclusions about the costs from the beginning of the ID Waiver in VA.
- Look at indirect and direct costs in the rates
- Need longer units: daily, weekly, monthly.
- They performed a survey of 36 states. Most SRS equivalents have a monthly rate.
- There are more options than group homes & SRS: shared living, family models and base rates on the ratio of staff to individual (e.g., 1:1 gets a higher reimbursement rate than a 1:3 ratio).

f) Voices of Virginia
- Close the institutions. End the waiting lists.
- Individuals can share apartments vs. living in group homes.

g) Debbie Burcham
- Applauds VA for trying to move to smaller group homes and exceptional rates.
- Keeping the 5-6 bed group home rate the same is not a good message to send to the GA.
- The gap between 10 and 25% is large; if 10% gets approved, there may not be enough providers willing/able to open homes of 4 or fewer, which will have an impact on the number of situations available for the Exceptional rate.
- In general, limiting the exceptional rate to 4 bed group homes may impact those happy in 5 bed homes that do need some additional support.

h) Tim Capoldo
- 5 bed group homes would operate at a loss in Norfolk.

i) VBPD
- Individuals should be able to choose their housing; support small group homes.
- The proposal seems to be about the number of beds vs. the needs of the individual. An individual should be able to change service providers vs. having to move if he/she is unsatisfied.
- Would like to see the data analysis behind the proposal.
- Do occupancy rates relate to group home size?
- Regarding slide #8, they question the assumption that individuals from the training centers require more hours or the exceptional rate especially if the individuals are in smaller settings.
- The state must attend to affordable housing models to offer individual care.

Small Group Reports

Over 120 individuals participated in a stakeholder meeting in response to Section BBBBB of the *2011 Acts of the Assembly* directing that the Departments review the current Intellectual Disabilities (ID), Day Support (DS) and Individual and Family Developmental Disabilities Support (DD) Waivers.

Stakeholders were invited to work in small groups to make recommendations regarding Virginia's Day Support Waiver. Instruction to the stakeholders is below:

Using the information provided as references and your knowledge of family needs, please identify in priority ranking, five services that you would most like to see added to the Day Support Waiver to make it most usable as a family support model of services. Beside each service, please state whether the decision was arrived at by consensus of the group or by majority vote (consensus is preferred where possible, but not mandatory).

Outcomes and Recommendations

Group I:

Additional services recommended in priority order:

1) All inclusive Companion/Attendant Services (Consensus)
2) Respite Services (Consensus)
3) Skilled Nursing – long term (Split consensus between #3 and #4 below)
4) Assistive Technology (Split consensus between #3 above and #4)
5) In-home residential

Group II:

General Comments from the group:

- Why don't we enhance the other waivers instead of splitting the pot of money by adding another waiver?
- Status should not be affected on another wait list because they have a Support Waiver
- Annual budget that is consumer directed to make this more individualized
- Leaves out people 22+ and under
- Waiver should be a short-term waiver
- Expand eligibility

Additional services recommended in priority order:

1) Therapeutic Services Expansion
2) Respite
3) Behavioral Support/Crisis Stabilization
4) Assistive Technology
5) Specialized Case Management

Group III:

General comments from the group:

- Combine three waivers into one comprehensive waiver under one waiver
- Whether through state plan or waiver

Additional services recommended in priority order:

1) Medical case management
2) Nursing oversight
3) Determination of need process, coordination and oversight
4) Rates – accuracy or inaccuracy based on true cost

Group IV:

General comments from the group:

- No need for Day Support Waiver – Both the ID and DD waivers already have day support components
- Carving out waivers specific services such as day support starts to isolate populations
- Why not discuss combining waivers
- Frustrating that DBHDS has asked for input from groups but shouts down groups
- We are tired of P.R. moves; looks like you are doing something, but not really;
- Doing what you want
- Where are the supports for individuals going to college?
- Supports should follow the person

Additional services recommended in priority order:

Greater access to behavioral consultation for families
Occupational Therapy
Physical Therapy
Speech Therapy

Group V:

General comments from the group:

- Individualized budgeting – case fund

Additional services recommended in priority order:

1) Reliable transportation (majority)
2) Respite (consensus) – 1:1 Supports to include Companion, Personal Assistance, In-home
3) Transition Services
4) Therapeutic Consultation (majority)
5) Assistive Technology (majority)

Group VI:

General comments from the group:

Drop Day Support and focus on EDCD
Both DD and ID – individualized budgeting (cash allocation)
Access to comprehensive waiver
People are unique
Age differences

Behavioral consultation
Revamp DS with Individual Budgets say $15,000 approx.
Not just…..needs according to individual
Additional services recommended in priority order:

1) using
2) Employment – rates to incentivize employment, not DS
3) Respite
4) Personal care support
5) Transportation (Note in margin for the above services: Not the top five)

Group VII:

General Comments from the group:

- Individualized budgeting
- Standards for Options Counseling

Additional services recommended in priority order:

1) In-home residential support (IHRS
2) Respite Services
3) Behavioral Supports
4) Transition Services (non-Department of Education) / Benefits Plan (age related)
5) Crisis Stabilization

Group VIII:

General Comments from the group:

- Allow for individualized budgeting with all services available to choose from
- Transportation is critical – it must be expanded, research needed, consumer direction/ individualized budgeting would enable for more flexibility for transportation

Additional services recommended in priority order:

1) Respite
2) Therapeutic Consultation
3) Flexible day support options (with focus on the needs if older individuals who are interested in social activities, but need more flexibility in schedule)
4) Environmental Modifications
5) Assistive Technology

Group IX:

General comments from the group:

- Range of capabilities / abilities between ID and DD populations
- Menu of services which is needs based
- Look at current "lower costs" people as target population
- Transportation for services other than "waiver" services / job coach to pay for transportation
- Providers – recruitment / retention
- Rates – manuals ID vs. DD
- ADLs vs. Skill Building Consolidation
- Independent living / training to develop skill sets outside a group home setting

- Services / supports should be “equal”
- Solutions that don’t put unnecessary burdens
- Parents – stay on top of needs
- Menu of services
- Integration

Additional services recommended in priority order:

1) Personal Care / Companion – personal attendant
2) PBS (Therapeutic Consultation)
3) In-home supports / residential
4) Assistive Technology / Environmental Modifications
5) Skills Training

Appendix F

Average Weekly and Annual Reimbursement for Residential Services per Individual

Sponsored Residential					
Percentile	Region	Average Hours	Current rate	Average weekly reimbursement	Average annual reimbursement
1-20th	NOVA	62	17.19	$1,060.93	$55,168.34
	ROS		14.95	$922.68	$47,979.45
21-40th	NOVA	82	17.19	$1,410.71	$73,356.87
	ROS		14.95	$1,226.88	$63,797.86
41-60th	NOVA	94	17.19	$1,624.24	$84,460.55
	ROS		14.95	$1,412.59	$73,454.64
61-80th	NOVA	107	17.19	$1,834.57	$95,397.53
	ROS		14.95	$1,595.51	$82,966.44
81-100th	NOVA	126	17.19	$2,161.64	$112,405.41
	ROS		14.95	$1,879.96	$97,758.05

Group Home					
Percentile	Region	Average Hours	Current rate	Average weekly reimbursement	Average annual reimbursement
1-20th	NOVA	63	17.19	$1,080.91	$56,207.25
	ROS		14.95	$940.06	$48,882.98
21-40th	NOVA	79	17.19	$1,361.48	$70,796.74
	ROS		14.95	$1,184.06	$61,571.34
41-60th	NOVA	88	17.19	$1,518.85	$78,980.11
	ROS		14.95	$1,320.93	$68,688.35
61-80th	NOVA	101	17.19	$1,732.02	$90,065.27
	ROS		14.95	$1,506.33	$78,329.01
81-100th	NOVA	129	17.19	$2,209.79	$114,909.08
	ROS		14.95	$1,921.84	$99,935.47

In home					
Percentile	Region	Average Hours	Current rate	Average weekly reimbursement	Average annual reimbursement
1-20th	NOVA	11	22.59	$251.75	$13,091.16
	ROS		19.65	$218.99	$11,387.39
21-40th	NOVA	25	22.59	$571.85	$29,736.37
	ROS		19.65	$497.43	$25,866.30
41-60th	NOVA	37	22.59	$839.11	$43,633.78
	ROS		19.65	$729.90	$37,955.01
61-80th	NOVA	49	22.59	$1,115.29	$57,994.94
	ROS		19.65	$970.14	$50,447.13
81-100th	NOVA	84	22.59	$1,890.50	$98,306.21
	ROS		19.65	$1,644.46	$85,512.05

Appendix G

Annual Congregate Residential Reimbursement for a 4-Bed Group Home, Impact by Composition of Individuals in Group Home

Group Home	Current ROS Annual Reimbursement	ROS Annual Reimbursement With 25% Increase
4 individuals (all with average hours)	$285,989.91	$357,487.39
4 individuals (3 with average hours and 1 with average hours in the highest quintile)	$314,427.20	$393,034.01
4 individuals (2 with average hours and 2 with average hours in the highest quintile)	$342,864.50	$428,580.62
4 individuals (1 with average hours and 3 with average hours in the highest quintile)	$371,301.79	$464,127.24
4 individuals (4 with average hours in the highest quintile)	$399,739.08	$499,673.85
Average Hours	91.97	
Highest Quintile Hours	128.55	

ROS - Rest of State
NOVA – Northern Virginia

Appendix H

Summary of Findings in JLARC 2006 Report Related to Reimbursement for Residential Services in the ID and DD Waivers

The Joint Legislative Audit and Review Commission (JLARC) reviewed the adequacy of Medicaid rates for home and community based care services in a 2006 report, *Assessment of Reimbursement Rates for Medicaid Home and Community-Based Services*. JLARC expressed concern that the low spending on HCBC services may not adequate to sustain the waiver program in the future. The JLARC report describes Virginia's waiver rates as "somewhat arbitrary" and JLARC acknowledges the situation Virginia, along with many other states, faces by having to develop rates based primarily on budgetary considerations rather than an assessment of provider costs. Despite criticism of Virginia's waiver rates, JLARC reported the continued increase of providers entering the market.

JLARC proposed increasing rates annually with inflation and/or rebasing rates. JLARC developed two approaches to rebasing rates: the living wage or the comparable position. The living wage was based on a pay rate that allows individuals to be compensated at a level high enough that they do not qualify for public assistance. The comparable position was based on hourly wages and fringe benefits for State employees in comparable positions. Both approaches built a rate from the direct care workers hourly wage and added fringe benefits and supervision, administration and overhead. The in-home residential rate was one of the rates benchmarked at the time. Two different overhead calculations were made for each rebasing approach. The rates in FY06 for ROS are fairly consistent with the Living Wage and approach the comparable position. The rates in FY06 for NOVA are not as competitive either with the Living Wage or the Comparable Position. JLARC determined that NOVA costs were 45% higher than ROS costs.

In-Home Residential Rate and JLARC Proposals

Region	Rate effective 7/1/2005	Living Wage 2006	Living Wage-Alt. Overhead 2006	Comparable Position 2006	Comparable Position-Alt. Overhead 2006
NOVA	$18.90	$22.38	$28.25	$24.86	$30.47
ROS	$18.90	$15.46	$19.51	$22.22	$27.13

JLARC raised three specific issues related to rates for ID and DD waiver services:

- Apply a Northern Virginia rate adjustment for ID and DD services. Rates for Northern Virginia were increased 15% over the ROS rates effective July 1, 2007.

- Revise the rate structure for HCB services provided in group settings. JLARC identifies Virginia as among the few that do not adjust group waiver service rates based on client health acuity or staffing ratios. While it may not exactly replicate group waiver service day rates based on client health acuity or staffing ratios, in practice the assumption is that the number of hours of service authorized is based on health acuity. In addition, as discussed in the introduction, restructuring of the waiver and the reimbursement methodology is a long-term initiative.
- Include general supervision as a billable service under congregate residential support. General supervision is not covered.